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S. HRG. 101-698

FEDERAL IMPLEMENTATION OF OBRA 1987 NURSING HOME REFORM PROVISIONS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

WASHINGTON, DC

MAY 18, 1989

Serial No. 101-4

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FEDERAL IMPLEMENTATION OF OBRA 1987 NURSING HOME REFORM PROVISIONS

THURSDAY, MAY 18, 1989

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Special Committee met, pursuant to notice, at 10:06 a.m., in room 628, Dirksen Senate Office Building, Hon. David Pryor (chairman of the committee) presiding.

Staff present: Portia Porter Mittelman, staff director; Christopher C. Jennings, deputy staff director; William F. Benson, chief of health and housing policy; Holly A. Bode, professional staff; Kristine L. Phillips, press secretary; Christine V. Drayton, chief clerk; and David G. Schulke, chief of oversight.

Present: Senators Pryor, Cohen, Kohl, Grassley, Heinz, Pressler, Shelby, and Warner.

OPENING STATEMENT BY SENATOR PRYOR, CHAIRMAN

The CHAIRMAN. Ladies and gentlemen, the committee will come to order.

First, an announcement. All witnesses will be limited to a strict 5-minute limit for their statements. Then, of course, questions may be asked by members of the committee to the witnesses. At 4½ minutes, I will give 30 seconds warning, and we will cut off the witness after 5 minutes. We apologize for that but we have several panels of witnesses today. We're going to have good participation by members of the committee and we hope that you will help us move this hearing along.

This hearing this morning, ladies and gentlemen, is about sweeping changes that were passed in the Omnibus Budget Reconciliation Act of 1987. There was continuing evidence of rampant poor quality in too many facilities in our nursing homes, inadequate systems for monitoring and enforcing the law, which demanded that something be done. It was, by the enactment of OBRA 1987 nursing home provisions.

These were the most significant nursing home reforms since Medicare and Medicaid first began to cover nursing home care. These reforms culminated in a decade-long effort to improve the quality of life and care for America's 1.5 million nursing home residents.

The passage of this law was a great accomplishment. All of the parties involved in its passage, despite their differing needs, should

be proud of what they accomplished together—a true consensus product.

Unfortunately, we just can't sit back and merely bask in this legislative accomplishment. This major achievement appears to be floundering. State officials, advocates for nursing homes residents, and nursing home providers who coalesced to make OBRA 1987 happen now tell us that the new system is in trouble—deep trouble. They tell us that there are serious problems with the way the Federal Government is implementing the law. In fact, many are predicting that if the current path is followed, the new law may not only be unworkable, but residents may actually be harmed in the process.

Recognizing the complexity of the law and the difficulties States and providers face today in converting to a new system of regulations and enforcement, OBRA laid out a timetable for the Department of Health and Human Services, the States, and the providers to meet, phased in over a period of several years.

The Department of Health and Human Services, through the Health Care Financing Administration, known as HCFA, is obligated to provide States and nursing home providers with the regulations to interpret the law and ensure that the new law is met. Otherwise, implementation will be difficult, if not impossible.

OBRA gave the Department of Health and Human Services some 10 deadlines. These 10 deadlines were to be met in 1988 and by March 1989. This is what this hearing is all about. The Department of Health and Human Services has not met one single deadline imposed upon them by law. To date, not one single regulation has been proposed for any of the 10 items required, such as establishing appeals procedures for residents adversely affected by the new screening requirements for mental illness and mental retardation.

OBRA required, however, beginning January 1 of this year, that States and facilities screen prospective residents to determine their status with regard to mental illness and mental retardation. Also, as of January 1, 1989, the States were to begin approving programs for training and testing nurse aides.

The Health Care Financing Administration failed to meet OBRA deadlines in both of these items, leaving States to comply with the new law with an absence of Federal guidance. Although HCFA has released nonbinding guidance for State nursing aide training programs and for preadmission screening, HCFA has not yet issued a notice of proposed rulemaking on these two requirements.

The most recent preadmission screening guidance is the fourth version of guidance circulated by HCFA to date. It is significantly different on critical points from each of the early versions, particularly in defining who would be screened out and denied access to the nursing facility.

Meanwhile, States and providers must conduct prescreening in order to make decisions as to who may not be admitted for nursing home care, putting States and providers in a real bind. Will they be accountable for guessing wrong in the absence of Federal rules which are required by law and for which the deadlines have passed?

HCFA can move rapidly when it wants to. In February 1989, HCFA issued a final rule that, effective August 1, 1989, creates an

entirely new set of rules for nursing homes. To ensure that these rules were followed, HCFA is implementing a new inspection system that States are to use—and providers and residents are subject to—by August 1 of this year, just a few months away.

There is an irony here that OBRA 1987 does not require that the new requirements and the new inspection system be in place until October 1, 1990. Under those circumstances, HCFA might be congratulated for their speed. I don't think that we can do that here. Many States and many providers across America are today struggling to meet current OBRA obligations without the benefit of required Federal direction.

The February rule poses very serious problems. It is a major change in regulation but since it is deemed final, comments from the public have no effect as to the rules that go into force in August 1989. This rule appears to contradict or otherwise weaken OBRA provisions such as standards for social services in nursing homes, which are essential to a meaningful quality of life for the nursing homes residents of America.

This new survey system necessary to enforce the new rule is being rushed through. The survey system implemented in 1988 after 10 years of litigation is thrown out the window as of August 1, 1989. State staff who actually go into nursing homes to determine compliance and identify problems have received no direction whatsoever or training in the new system. There is no way that procedures for the new survey system can be tested as OBRA dictates.

HCFA's self-imposed deadline of August 1 of this year may well lead to frequent and prolonged challenges to the findings of inspections staff, and more significantly, actual harm to the nursing homes residents.

HCFA is even further behind in establishing the necessary elements of the enforcement system and those that have been discussed by HCFA suggest a dramatic weakening of the States' role in enforcing the law in most of the nursing homes. Congress, in enacting OBRA, intended to strengthen the enforcement capabilities of the States—I emphasize, the enforcement capabilities of the States.

Congress intended to strengthen HCFA's ability to sanction poor providers. The new enforcement system envisioned by the Department of Health and Human Services would strip HCFA of its ability to issue civil penalties, leaving that authority to the Inspector General.

Rather than concentrating on complying with OBRA in an orderly and timely way, and to minimize the transitional difficulties faced by States and providers and, ultimately, by residents, the Department of Health and Human Services has chosen a different approach.

Instead, the Department has now devoted considerable amounts of time, energy, and resources to implementing a new set of rules and procedures 14 months before Congress intended. Congress did not establish an October 1, 1990, start date to delay implementation, but simply to provide a reasonable opportunity for States and providers to be prepared to comply fully with the law with timely

and proper guidance from Department of Health and Human Services.

Today's hearing will dissect some of these problems. We're going to lay them out on the table; we're going to see what is wrong; and we're going to try to get to the bottom of this morass which is not only adding to the confusion of the moment but, more importantly, is taking away ultimately from the quality of life that OBRA 1987 attempted to implement.

[The prepared statements of Chairman Pryor and Senator John Breaux follow:]

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United States Senate
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SENATOR DAVID PRYOR, CHAIRMAN
SENATE SPECIAL COMMITTEE ON AGING
OPENING STATEMENT
FEDERAL IMPLEMENTATION OF OBRA 87
NURSING HOME REFORM PROVISIONS
HEARING

MAY 18, 1989

Good morning. In late 1987, Congress passed major -- indeed sweeping -- changes in the way that care is to be provided in our Nation's thousands of nursing homes. This new law was incorporated in the 1987 Omnibus Budget Reconciliation Act, or OBRA 87 (P.L. 100-203).

Continuing evidence of rampant poor quality in too many facilities, along with the growing recognition that our systems for monitoring the care and enforcing the law were not working, demanded that something dramatic be done. And it was -- by the enactment of the OBRA 87 nursing home provisions.

OBRA 87 represents the most significant nursing home reforms since Medicare and Medicaid first began to cover nursing home care. These reforms culminated a more than decade-long effort to improve the quality of life and care for the nearly 1.5 million older and disabled Americans whose condition requires them to call their skilled nursing facility or intermediate care facility home.

The passage of this law was a great accomplishment. All of the parties involved in its enactment should be proud of what they accomplished together -- despite genuine differences in perspective and needs -- to reach a comprehensive product that was acceptable and achievable.

Congress, the Administration, nursing home providers, state regulators, and consumers together made this important law happen. And, most important of all, for the first time the focus of the law was put directly on the quality of life of and care for nursing home residents.

Unfortunately, we cannot sit back and merely relax. There are significant indications that this major effort is seriously floundering. It is a complex law and there is no question that it poses considerable challenges in putting it into place. But these difficulties must not be made worse or even impossible because of bureaucratic obstacles or misplaced priorities.

State officials, advocates for facility residents, and nursing home providers -- who coalesced to make OBRA 87 possible - now tell us that the new system is in trouble. They have serious concerns about how the federal government is putting the new law into effect. In fact, many are predicting that if the Department of Health and Human Services (DHHS) continues on its current path, the new law may not only be unworkable, the residents may actually be harmed.

Recognizing the complexity of the law and the difficulties states and providers face in converting to a new system of regulation and enforcement, OBRA laid out a clear timetable for the DHHS, the states, and providers to meet, phased in over a period of several years.

The initial obligations rest with DHHS, through the Health Care Financing Administration (HCFA), to put key systems into place and to provide states and nursing home providers with the regulations guidance that they need to ensure that the letter and spirit of the new law is met. Otherwise, this task will be difficult, if not impossible.

OBRA gave DHHS some ten deadlines to meet in 1988 and by March 1989. DHHS has not met a single one of these deadlines, dating back to January 1, 1988. To date, not a single regulation has been proposed for any of the ten items required -- such as establishing alternative sanctions to dropping a facility from Medicare or Medicaid, or establishing appeals procedures for residents adversely affected by the new screening requirements for mental illness or mental retardation.

OBRA required, however, beginning January 1 of this year, that states and facilities screen prospective residents to determine their status with regard to mental illness and mental retardation. Also, as of January 1, 1989, states were to begin approving nurse aide training and competency evaluation programs. HCFA failed to meet its statutory deadlines on both these items leaving states with the burden of complying with the new law in the absence of much-needed federal guidance.

HCFA has only just released a notice to state Medicaid agencies offering non-binding guidance on states' nurse aide training and evaluation programs and on criteria for the pre-admission screening of prospective residents for mental illness or mental retardation. HCFA has not yet issued a notice of proposed rulemaking on these two major requirements. The preadmission screening guidance is significantly different on critical points than its previous versions -- particularly in defining who would be "screened out" and denied access to the nursing facility.

Meanwhile, states and providers must conduct screening and make decisions as to whether or not to admit elderly and disabled Americans seeking nursing home care, putting states and providers in a real bind as to what the law requires. Will they be accountable for guessing wrong in the absence of federal rules? For states, providers and, most important, for residents, the consequences can be quite severe. We will hear more about this today.

HCFA can, however, move rapidly -- when it wants to. In February, 1989, HCFA issued a Final Rule that, effective August 1, 1989, creates an entirely new set of rules for nursing homes. To ensure that these rules are followed, HCFA is implementing a new inspection system that states are to use -- and providers and residents are subject to -- by August 1 of this year.

The irony is that OBRA 1987 does not require that the new requirements and the new inspection system be in place until October 1, 1990. Under other circumstances, HCFA might be congratulated for their speed. I do not think that we can do that here. Many states and providers are struggling to meet their new obligations for nurse aide training and preadmission screening in the absence of required federal direction. Other key OBRA requirements will soon kick in for the states for which critical required HCFA regulations have not been provided.

Moreover, the February Final Rule poses serious problems. It is a major change in regulations but since it is deemed final, comments from the public have no effect as the rules go into force in August. The rule appears to contradict or otherwise weaken OBRA requirements such as standards for social services in nursing homes, which are essential to a meaningful life for residents.

The new survey system put in place as a result of the February rule is being rushed through. A survey system implemented in 1988 after ten years of litigation is thrown out the window as of August 1, 1989. State staff who actually go into nursing homes to determine compliance and identify problems have received no direction or training on the new system.

OBRA, in anticipation of an October 1, 1990 start, requires that protocols for the new survey system be tested and validated by January 1, 1990. This duty notwithstanding, HCFA is moving ahead with the new system to meet their self-imposed deadline of August 1 of this year. The result may well be frequent and prolonged challenges to the findings of inspections staff, and, more significantly, actual harm to facility residents.

Of particular concern to states, I'm sure, is responding to the cost of the new survey system in the absence of adequate time -- which Congress built into OBRA. In the preamble to the February rule, HCFA states that "...we believe there will be little or no increased cost for State certification activities." Yet, draft "Survey Procedures" for facility surveys circulated by HCFA last month state on the cover page "Note: These survey procedures assume a 40% increase in budgeted surveyor hours, from the current 64 hours to 106 hours..."

HCFA is even further behind in establishing the enforcement mechanisms to ensure that once problems are spotted, they are corrected or appropriately sanctioned. Without adequate provision for enforcement, nursing home standards are too often meaningless. This was a central point of the OBRA 87 requirements and the decade worth of work behind it.

Moreover, the rudiments of the enforcement system that have been discussed by HCFA suggest a dramatic weakening of the states' role in enforcing the law in most of the nation's nursing homes. Congress, in enacting OBRA 87, intended to strengthen the enforcement capabilities of the states.

Congress also intended to strengthen HCFA's ability to sanction poor providers. It appears that the new enforcement system envisioned by DHHS would strip HCFA of its ability to issue civil penalties and leave that authority only in the hands of the Inspector General, possibly creating one more lengthy step in the process of correcting serious problems.

Rather than concentrating on meeting the requirements of the law in an orderly and timely way -- and to minimize the transitional difficulties faced by states and providers and, ultimately, by residents -- DHHS has chosen a different approach. Deadlines are ignored and critical guidance has not been provided to states and providers.

Instead, DHHS has devoted considerable energy, time and resources to implementing a new set of rules and procedures fourteen months before Congress intended. Congress did not establish an October 1, 1990 start date to delay implementation -- it was to provide a reasonable opportunity for states and providers to be prepared to comply fully with the law with timely and proper guidance from the DHHS.

Today's hearing will provide us with a better understanding of this situation. This Committee has distinguished itself over the years in putting the spotlight on the problems of nursing home residents and solutions to those problems. With today's expert witnesses, we continue this legacy with our first look at the way this important law is being implemented.

JOHN BREAUX
LOUISIANA

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STATEMENT OF SENATOR JOHN BREAUX

SENATE SPECIAL COMMITTEE ON AGING

OBRA NURSING HOME REFORM PROVISIONS

Mr. Chairman, I thank you for the opportunity to comment on the implementation of the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987. I appreciate your bringing this matter before the Committee, as well as the fine way that you have gone about conducting the operations of the Special Committee on Aging as its Chairman.

The screening procedures for nursing home residents that are required under OBRA have, largely due to the way that the Health Care Financing Administration has gone about implementation, become unnecessarily complicated and threaten to become a serious burden on nursing home operators. So much so that my home state of Louisiana is one of four states in which the Secretary of Health and Human Services and the State health department have been taken to court by nursing home operators.

Louisiana nursing homes are not specifically contesting the need for or validity of the OBRA reform provisions. What they are contesting is the sloppy implementation of the new law by the federal agency and, as a result, the inability of the state agency to set proper guidelines. What they are asking for is a set of final rules on pre-screening requirements before they are held accountable for the monetary costs that would result from non-compliance. I am concerned that we are holding nursing homes responsible without properly defining what compliance is. I look forward to hearing from the Health Care Financing Administration's representative as to their opinion on this.

There have been a number of other problems associated with OBRA's nursing home requirements, many having to do with the dates of implementation of specific provisions. The Committee staff has provided us with a long list of implementation dates that the Health Care Financing Administration has missed. Also, the procedure by which HCFA has put out their nursing home reform rules has been unusual. Instead of the regular rule-making process and period for comment, HCFA presented the public with a "final" set of regulations on February 2, 1989. The public's only opportunity for comment is to be in reference to these "final" rules. This procedure has raised some question as to whether HCFA has any intention of seriously considering public comment. It also raises the question of whether or not nursing homes can count on the February 2, 1989 rules as being truly "final."

Again, I want to thank the Chairman for bringing the issue of OBRA implementation before this Committee. It has been a matter of great concern to the nursing home industry in Louisiana, as well as a source of confusion, and I am hopeful that these proceedings will allow us to clear the air to some degree as to the future guidelines for nursing home reform standards.

The CHAIRMAN. Senator Cohen.

STATEMENT OF SENATOR WILLIAM COHEN

Senator COHEN. Thank you, Mr. Chairman.

I have a prepared statemment I would like to submit for the record.

The CHAIRMAN. The statement will be placed in the record in full.

Senator COHEN. Mr. Chairman, if you turn on the morning news, you will see that our attention has been focused principally the past week or so upon China and the turmoil that is currently taking place there. There is, in fact, a Chinese proverb, a paradox, that says, "man fears old age while praying for a long life." It seems that the elderly of any country have a basis for fear: they are no longer earning wages, their savings may be ravaged by inflation, they may have physical or mental impairment, they may not have families to care for them and they may face the prospect of entering a nursing home.

This committee has long worked to assure that people who enter nursing homes will have their rights protected, that they will maintain a sense of dignity while they are in the nursing home.

One of the first bills that I introduced was back in 1973, as a freshman Member of the House of Representatives, entitled "The Nursing Home Patients Bill of Rights." It was opposed at that time; it was reintroduced again in 1976, 1978, again here in the Senate in 1979, and finally was incorporated by regulation into law and then codified with the passage of the Omnibus Budget Reconciliation Act of 1987. So there has been a long-term commitment to seeing to it that we do, in fact, protect the rights of individuals who are in nursing homes, assure adequate care, and set standards.

It seems that the situation now is that HCFA has come with too little, too soon—too little time for comment, too little time for analysis, too little time to make constructive recommendations, and coming too soon and long before Congress intended for the regulations to go into effect. It is an ironic situation, Mr. Chairman, that after all of the years that we've been struggling to have something in place to guarantee these kinds of rights, that now we find ourselves in a situation where we may not have enough time to make a constructive contribution to the regulations.

I commend you for holding the hearing. I think that you've set a number of hearings in this committee which indicate your commitment to the issue and I am pleased to be here today.

The CHAIRMAN. Senator Cohen, thank you.

[The prepared statement of Senator Cohen follows:]

Senator William S. Cohen
May 18, 1989
Special Committee on Aging

HCFA Implementation of Nursing Home Reform

Mr. Chairman, I would like to join my colleagues in commending you for convening this hearing of the Special Committee on Aging. Quite in keeping with your longstanding and sincere interest in the welfare and well-being of the nation's elderly, your young tenure as Chairman of this Committee already well shows your commitment and diligence. You have hit the ground running and show no sign of slowing down. I was pleased to see that the Committee's recent hearing was very enlightening and successful and that you already have several more in the works.

A report issued by the National Academy's Institute of Medicine in March 1986 and a subsequent investigation conducted by this Committee under the Chairmanship of Senator Heinz concluded that there were serious problems of abuse and neglect in far too many of the nation's nursing homes. The Institute of Medicine's study noted that, in many government-certified nursing homes, "individuals who are admitted receive very inadequate -- sometimes shockingly deficient -- care that is likely to hasten the deterioration of their physical, mental, and emotional health. They also are likely to have their rights ignored or violated, and may even be subject to physical abuse."

The Congress was justifiably proud of the nursing home reform provisions incorporated into the Omnibus Reconciliation Act of 1987. These reforms represented an ambitious step toward improving the quality of care and quality of life in the nation's nursing homes. The new legislation sought to improve staffing and staff training at long-term care facilities and to improve the ways and means by which the states and the federal government monitor and ensure the quality of nursing home care. I was especially pleased that the nursing home reform legislation set forth requirements to protect the basic rights of long-term care facility residents.

The protection of "residents' rights" in long-term care facilities has long been one of my concerns. I first introduced legislation to guarantee the basic civil and human rights of nursing

home patients in 1973, when I was a Member of the U.S. House of Representatives. During the 99th Congress, I introduced the "Long-Term Care Residents' Rights Act," which had a lot in common with the nursing home residents' rights provisions eventually enacted in 1987. I was glad to see a national standard of rights and basic guarantees to compassionate care for residents of nursing homes finally written into law.

The Committee convenes today to see what has been made of our handiwork by those charged with helping states and long-term care facilities to implement its far-reaching and complex provisions. I would note that the Committee is well-equipped to look into the question of how well progress to date represents the congressional intent of the nursing home reform legislation enacted in 1987. The Chairman and Ranking Member worked closely with my colleague from Maine, Senator Mitchell, in developing the "Medicare and Medicaid Nursing Home Quality Care Amendments of 1987" which became the nursing home reform provisions of OBRA 1987. They, along with Senators Bradley and Glenn, serve on both the Finance Committee and this Committee, and were sponsors and collaborators in the long legislative process of nursing home reform.

Specifically, the Committee will want to address the question of whether HCFA's publication and implementation of nursing home reform regulations reflects an agenda set forth by Congress or unfinished business from previous administrative action. I am concerned that the short shrift HCFA has given to the usual notice and comment provisions of the Administrative Procedures Act could result in legal snarls and other problems that could undermine the the intent of nursing home reform. The Committee needs to review the timetable that HCFA has itself observed and that which it has imposed upon states and providers. We must attempt to determine whether HCFA has used too much stick and not enough carrot in efforts to implement nursing home reform.

I am glad to be able to take part in this proceeding and I look forward to the testimony of the witnesses. Again, I would like to commend the Chairman for convening this hearing today.

The CHAIRMAN. Senator Grassley.

STATEMENT OF SENATOR CHARLES GRASSLEY

Senator GRASSLEY. Mr. Chairman, I want to thank you, too. If my town meetings in Iowa and the people who come there and what they have to say are any indication of what Congress ought to be working on, then this hearing is very timely and I assume that you have heard the same story in Arkansas, as well as the other States here, or this meeting wouldn't be held.

So with this hearing, it seems to me that we're one in one of the most recent chapters of a story with many chapters, a story that doesn't seem to want to end, and I believe that this current phase of the nursing home reform effort began as far back as 1978 and since then there has been what seems to be an unbroken chain of actions by the Department of Health and Human Services and then reactions by the Congress and this hearing is the latest reaction by the Congress to a departmental action on this problem. As far as I can tell, this hearing is a much needed reaction.

The Health Care Financing Administration's implementation of the 1987 OBRA nursing home reform initiatives seems strange, to put it mildly. Among other things, HCFA has issued final regulations for the nursing home conditions of participation without taking into consideration comments from interested parties. The agency will apparently rely on interpretive guidelines not yet issued rather than regulations to provide guidance for the interpretation of statutory language. As I understand it, it is not the intention of HCFA to publish these interpretive guidelines in the Federal Register but to announce them through more informal means. In some places, the regulations for the condition of participation rely on statutory language without further explanation.

Despite what on the surface at least appears to have been an inadequate and inappropriate response to the OBRA nursing home provisions by HCFA, the agency has made it clear that it will require compliance with some key OBRA provisions as of January 1989. Perhaps the departmental leadership feels that it has no choice but to require compliance. But if that is the case, then HCFA surely is under an obligation to facilitate that implementation by publication of consistent guidelines in a timely matter. I hope we get some idea from this hearing about what we should do about this situation because it seems to me that we have a major problem here.

The bottom line, Mr. Chairman, is that if HCFA can't state very clearly to the people who are covered by the regulations exactly what the law means and doesn't mean, exactly what they have to do and don't have to do, then we in the Congress are going to have to do that or delay the implementation because if there is anything the people of this country are entitled to, it is to know what the law is.

On your program is a constituent of mine—an outstanding person in this area who will be offering some good testimony, because I've had an opportunity to hear her testimony—Ms. Petrowsky. I want to introduce her to the group just by name and through this process because I'm going to be at the subcommittee

on HUD and Judiciary as well, over the next part of the morning. I may get back here to hear her testimony but if I don't, I want her to know that I have read it and that I'm sure that she will have good Arkansas hospitality displayed to her.

The CHAIRMAN. Absolutely.

[The prepared statement of Senator Grassley follows:]

STATEMENT BY SENATOR CHARLES E. GRASSLEY ON THE OCCASION OF A HEARING OF THE SPECIAL COMMITTEE ON AGING ON IMPLEMENTATION OF OBRA NURSING HOME REFORM

THANK YOU, MR. CHAIRMAN.

I DO HAVE A FEW REMARKS I WOULD LIKE TO MAKE.

WITH THIS HEARING WE SEEM TO BE IN THE MOST RECENT CHAPTER OF A STORY WITH MANY CHAPTERS, A STORY THAT DOESN'T SEEM TO WANT TO END.

I BELIEVE WE BEGAN THE CURRENT PHASE OF THE NURSING HOME REFORM EFFORT AS FAR BACK AS 1978 AND THERE HAS BEEN, SINCE THAT TIME, WHAT SEEMS TO BE AN UNBROKEN CHAIN OF ACTIONS BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND REACTIONS BY THE CONGRESS. THIS HEARING IS THE LATEST REACTION BY THE CONGRESS TO A DEPARTMENTAL ACTION ON THIS PROBLEM.

AND, AS FAR AS I CAN TELL, THIS HEARING IS A MUCH NEEDED REACTION.

THE HEALTH CARE FINANCING ADMINISTRATION'S IMPLEMENTATION OF THE 1987 OBRA NURSING HOME REFORM INITIATIVE SEEMS STRANGE, TO PUT IT MILDLY. AMONG OTHER THINGS:

o HCFA HAS ISSUED FINAL REGULATIONS FOR THE NURSING HOME CONDITIONS OF PARTICIPATION WITHOUT TAKING INTO CONSIDERATION COMMENTS FROM INTERESTED PARTIES.

o THE AGENCY WILL APPARENTLY RELY ON "INTERPRETIVE GUIDELINES", NOT YET ISSUED, RATHER THAN REGULATIONS, TO PROVIDE GUIDANCE FOR INTERPRETATION OF STATUTORY LANGUAGE. AS I UNDERSTAND IT, IT IS NOT THE INTENTION OF HCFA TO PUBLISH THESE "INTERPRETIVE GUIDELINES" IN THE FEDERAL REGISTER, BUT TO ANNOUNCE THEM THROUGH MORE INFORMAL MEANS.

o IN SOME PLACES THE REGULATIONS FOR THE CONDITIONS OF PARTICIPATION RELY ON STATUTORY LANGUAGE WITHOUT FURTHER EXPLANATION.

DESPITE WHAT, ON THE SURFACE AT LEAST, APPEARS TO HAVE BEEN AN INADEQUATE AND INAPPROPRIATE RESPONSE TO THE OBRA NURSING HOME PROVISIONS BY HCFA, THE AGENCY HAS MADE IT CLEAR THAT IT WILL REQUIRE REQUIRE COMPLIANCE WITH SOME KEY OBRA PROVISIONS AS OF JANUARY, 1989.

PERHAPS THE DEPARTMENTAL LEADERSHIP FEELS THAT IT HAS NO CHOICE BUT TO REQUIRE COMPLIANCE. BUT IF THAT IS THE CASE, THEN HCFA SURELY IS UNDER AN OBLIGATION TO FACILITATE THAT IMPLEMENTATION BY PUBLICATION OF CONSISTENT GUIDELINES IN A TIMELY MANNER.

MR. CHAIRMAN, I HOPE WE CAN GET SOME IDEA FROM THIS HEARING ABOUT WHAT WE SHOULD DO ABOUT THIS SITUATION, BECAUSE IT SEEMS TO ME THAT WE HAVE A MAJOR PROBLEM HERE.

THAT IS ALL THAT I HAVE FOR THE MOMENT. I LOOK FORWARD TO THE TESTIMONY.

The CHAIRMAN. Thank you, Senator Grassley.
Senator Kohl.

STATEMENT OF SENATOR HERBERT KOHL

Senator KOHL. Thank you, Mr. Chairman. I want to commend my colleagues from Arkansas, Pennsylvania, and New Jersey for their efforts in the Nursing Home Reform Act back in 1987. It is obviously an important issue and I would imagine the present situation is not exactly what was envisioned at that time.

I also want to express my appreciation to the witnesses who have taken time out of their busy schedules to shed some light on this matter today. While I will have to leave shortly to attend to other committee business, I want to assure the witnesses that I will review the written testimony.

This is an issue that is of great concern to many of the residents in Wisconsin, as well as to the service providers who are now caught between a rock and a hard place. Of greatest concern to me is the manner in which the regulations have been proposed by the Health Care Financing Administration. They are late, they are confusing, they are all but void of true public comment, and in some ways they just don't make a whole lot of common sense. They have wreaked havoc in many States.

In Wisconsin, specifically, the lack of guidelines for the preadmission screening program coupled with admission denial for any individual with a mental disorder or developmental disability since January 1, 1989, have resulted in a very limited number of beds available to those in need of appropriate services. According to officials in Sheboygan County, WI, if an individual with a developmental disability requires hospitalization and it is determined they require active treatment services based on their identified needs, there is no local facility that can admit them. Until an appropriate placement can be located, the individual would continue to reside in a bed in the local acute psychiatric unit of a private hospital at the approximate cost of $275 a day. This, in effect, removes from availability one bed for the treatment of an individual with an acute psychiatric need and arguably does not, despite Congressional intent, provide the most appropriate and efficient care for the disabled.

Mr. Chairman, this is what is happening despite the fact that the Sheboygan County Comprehensive Health Care Center is a new comprehensive program that meets the needs of the disabled community. It exceeds the requirements of both the Wisconsin Administrative Code and all Federal standards for ICF/MR's. The focus of the ICF/MR program is to provide each resident with the training and service necessary to help them become as independent as possible. It is an active treatment program, fully staffed with a team of professional medical, rehabilitation, and social service personnel. So what is the sense of denying the developmentally disabled access to these services? Where is the logic in the present dilemma created by the Health Care Financing Administration? How many other quality providers, disabled, and families are struggling with the problem before us today?

I understand that the most recent set of rules promulgated by the HCFA attempts to address some of these questions. It is also my understanding, however, that even those rules are subject to change. We need some clear guidance for our State and care providers. I am hopeful that today's hearing will move us in that direction and so I commend the chairman for holding these hearings and I'm looking forward to the testimony. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kohl. We're very sorry that your Milwaukee Bucks lost on Sunday afternoon. [Laughter.]

Senator Heinz has gone down to the Finance Committee to make a quorum and he will return in a moment or two. Until Senator Heinz returns, Senator Pressler has just arrived and I wonder, Senator Pressler, if you would like to make an opening statement?

STATEMENT OF SENATOR LARRY PRESSLER

Senator PRESSLER. Thank you very much, Mr. Chairman, for chairing this important hearing. I think it is very timely.

Let me say that the nursing home provisions contained in the Omnibus Reconciliation Act of 1987 are of great concern in my State of South Dakota. This hearing addresses a very timely and important concern—the care of the elderly residing in nursing homes.

I have heard from many constituents regarding positive and negative aspects of the nursing home provisions. Provisions highlighted in my testimony are preadmission screening of persons for mental retardation, developmental disabilities, and/or mental illness; nurse aide training requirements; new survey process for long-term care; enforcement process; and cost of implementing the nursing home provisions.

The law requires preadmission screening for mentally ill or mentally retarded individuals prior to admission to Medicaid-certified nursing facilities effective January 1, 1989. Further, the Health Care Financing Administration is interpreting the law so that all new residents to Medicaid-certified facilities must be screened regardless of the source of payment.

HCFA thus far has failed to publish regulatory criteria for nursing facility placements that involve mental retardation, mental illness, and related conditions, and yet HCFA threatens to sanction nursing homes for violating provisions of the act that took effect on January 1, 1989, including the loss of reimbursement.

The requirements for preadmission screening, in the absence of regulations outlining their scope, place the individuals affected by the law in an unfortunate position. The result is a 50-State experiment in implementation. In some cases, this results in delayed or denied access to nursing home care.

On the nurse aide training requirements, the law requires that nurse aides have a minimum of 75 hours of initial training and prohibits nursing homes from employing a nurse aide beyond 4 months without completion of training and competency evaluation.

The State of South Dakota has been working toward implementation of this requirement for about 1 year. The State regards the standardization of requirements for nurse aide training as a posi-

tive development in the improvement of the quality of care. However, the lack of final regulations has made their efforts very difficult. The State has received virtually no guidelines or assistance from HCFA that would allow it to proceed with the development of an acceptable training and testing program. South Dakota submitted its standards for a training program by August 31, 1988, the deadline designated by HCFA. Yet HCFA did not send out final program standards until April 12, 1989. This places the State and nursing homes in a very difficult position. How can nursing homes evaluate currently employed nurse aides when there are no guidelines?

Second, the cost of implementing the program must be assumed by the home. How can nursing homes develop a budget when they do not have any idea of the standards? Knowledge of the standards is essential for reliable budget estimates.

A nurse aide registry is required by March 1, 1989. To date, no guidelines have been issued by HCFA for this registry.

A new survey process will be in place beginning August 1989. The new survey does not include all the provisions set forth in the Omnibus Budget Reconciliation Act of 1987. A fragmented process like this one will only lead to confusion for nursing homes and survey agencies. HCFA sent the document containing the survey process during the first week of this month with instructions to comment by May 12. The opportunity for comment is appreciated but the short time frame makes it extremely difficult for people to do a competent review.

Mr. Chairman, the enforcement process in OBRA mandates a system of State and Federal alternative remedies to be used in addition to or in lieu of termination of Medicare and Medicaid facilities that are out of compliance with requirements for participation. The law required that guidance be given to States by October 1, 1989. The interpretation of this provision has established a rather complicated, detailed enforcement process. The details of the process are far too complex to discuss but they would place unnecessary stress on some nursing homes.

One report suggests that HCFA will find approximately 80 percent of the nursing homes out of compliance under this new proposal. If this is true, something is wrong with the review process. How can we go from a current 5 percent noncompliance rate to an 80 percent noncompliance rate?

A major concern of nursing homes is who will pay for the cost of implementing OBRA. If the quality of care is dependent on the level of reimbursement, as has been stated by the Institute of Medicine and described in research studies, then reimbursement rates must be adjusted to include implementation of these provisions. The present financial needs of nursing homes no longer can be ignored by the regulatory process. The frail, elderly consumer will soon be left with nothing but an empty promise.

Concurrent with cost is the issue of discrimination. If reimbursement rates are not adjusted to accommodate the implementation of the provisions set forth in OBRA, then facilities will seek to fill their beds with private pay residents. What will happen then to the residents on Medicaid?

In conclusion, Mr. Chairman, let me say that a number of very critical problems exist in the OBRA implementation process. The question we must ask ourselves is who will be served in the process. As a member of the Senate Aging Committee, I am very concerned about the effect of this process on the frail elderly, and their families. Either the implementation of these regulations should be delayed indefinitely or at least until guidelines are in place and reimbursement rates reflect the added cost of compliance.

HCFA must take leadership and work with the nursing home providers and States to ensure an orderly process that respects the needs of our elderly.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Pressler, thank you very much for your statement.

We'll call our first panel at this time: Janet Tulloch from Washington, DC; Susan Rourke, president of the National Citizens Coalition for Nursing Home Reform; and Bruce Spitz, Director of Special Projects, the American Red Cross. If the three of you would please come forward at this time.

Let the record note that Ms. Tulloch, who will be our first witness, is also accompanied by Toby Edelman, with the National Senior Citizens Law Center. From time to time, Toby may give a part of Ms. Tulloch's statement.

We look forward to your statement, Ms. Tulloch. We are also very aware of your splendid book, "A Home Is Not A Home." I assume that relates to 21 years of living in a nursing home.

Ms. Tulloch.

STATEMENT OF JANET TULLOCH, WASHINGTON, DC, NURSING HOME RESIDENT AND AUTHOR OF "A HOME IS NOT A HOME," ACCOMPANIED BY TOBY EDELMAN, NATIONAL SENIOR CITIZENS LAW CENTER

Ms. TULLOCH. Thank you and thanks for your knowledge of what HCFA has done. I am also grateful to be here. Because of your time limits, I might ask Toby Edelman to read my statement for me.

Thank you very much.

The CHAIRMAN. Thank you, Ms. Tulloch.

Toby, would you like to read her statement?

Ms. EDELMAN. Yes, thank you very much, Senator Pryor.

I would like to thank the committee for inviting me to testify this morning on the Department of Health and Human Services' implementation of the nursing home reform law that Congress passed in December 1987. HHS' implementation has been a serious disappointment to those of us who greeted enactment of the law in December 1987 with such hope.

I am one of the resident plaintiffs in the lawsuit that challenges the final regulations on nursing home requirements that the Department published in February 1989 as final rules. Since that lawsuit is now before the court, I wish to restrict my comments to summarizing what I wrote in my declaration in that case. I have

provided the committee with a complete copy of my declaration and the complaint, as well.[1]

Now a 65-year-old resident, I entered a nursing facility 21 years ago when there was no family member with whom I could live. Persons with cerebral palsy do not usually become candidates for long-term care at such an early age, but because of a family history of cancer, including myself, I thought it wise to establish myself in a multi-care environment in which I could receive a variety of levels of care as my needs changed while still maintaining an independent and socially active life. In other words, I moved into a nursing home to live as fully as I was able—physically, mentally, and socially.

To achieve these goals, I have remained an active member of St. Alban's Parish, Washington, DC, and have received formal training in pastoral counseling. From Queen's University in Canada, I took 3 years of correspondence courses in theology. Attending church conferences for many years, I have not only fully participated in workshops, I lead one myself called "Whose Handicap?"

My second book, "A Home Is Not A Home," was published in 1975. From this I wrote articles as a consultant for the National Institute of Mental Health's Center on Aging, and have published articles in other professional journals. I was appointed to a Mayoral task force to re-write nursing home regulations for the District of Columbia. I consider myself qualified to defend the intent of the Institute of Medicine report, "Improving the Quality of Care in Nursing Homes," and of OBRA.

Many of us greeted the passage of OBRA with elation. OBRA meant light at the end of a very dark tunnel of subtle abuse. For example, nurse aide training, required under Federal law for the first time by OBRA, would mean more skill and sensitivity in our personal physical care. It would mean an end to biting our lips against the horror of clumsy invasions of privacy, or at best, patiently guiding the more willing hands to do the more personal tasks.

Our elation has now turned to disappointment because of HCFA's disregard of OBRA and its failure to implement the reform law properly. The 1989 requirements not only contradict the intent of the IOM report and OBRA; they do not make it possible for another person in my situation to be encouraged or motivated to view life in a nursing home as a way of living rather than a means of dying. As I wrote in my declaration to the court, I believe that if HCFA fails to rescind the February requirements, nursing homes will become chaotic warehouses allowing systems to deteriorate to a degree from which it will take many decades to return.

I feel that the February requirements with their many waivers—nurse staffing and dietary requirements, for example—will allow the easiest solution wherever possible to every situation. Incentives will falter, not always intentionally, but because HCFA has created the opportunity. Regulations which allow compromise will encourage permission for further compromise. How easy it has always

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[1] See appendix, p. 165.

been to ignore a call bell or to skip giving a thirsty resident fruit juice because the supper trays will arrive in about an hour.

People who live in nursing homes receive poor care and become depressed when they are surrounded by insufficient numbers of staff who are untrained and poorly motivated. The remedy of this is detailed requirements which will promote and not jeopardize the well-being of each resident, and which will creatively guide the imaginations of paid, trained workers.

The proposed conditions of participation in 1987 were a hopeful first step in the right direction as reform under the old law. But OBRA aimed higher. The February 1989 requirements failed to achieve the goals of OBRA.

Ms. TULLOCH. I am grateful for the passage of OBRA and thank you for this opportunity to speak on behalf of its appropriate implementation.

The CHAIRMAN. Thank you very much, Ms. Tulloch, for your contribution and your courage for coming here today.

Toby, thank you also. We may have a question or two in a moment.

Susan Rourke, please. Susan, once again, is the President of the National Citizens' Coalition for Nursing Home Reform. We welcome your statement.

STATEMENT OF SUSAN ROURKE, PRESIDENT, NATIONAL CITIZENS COALITION FOR NURSING HOME REFORM; EXECUTIVE DIRECTOR, CITIZENS FOR BETTER NURSING HOME CARE

Ms. ROURKE. Thank you very much. In addition to being President of the National Citizens Coalition, I'm Executive Director of Citizens for Better Care, which is a Michigan consumer agency providing protection and assistance in the Ombudsman program in the State of Michigan.

We appreciate today the opportunity to testify and I would like to especially thank Senators Pryor, Heinz, and Cohen for the leadership you have taken over the past several years in the area of nursing home reform, really culminating in the passage of OBRA.

The Coalition represents over 300 local and State groups throughout the country which are gravely concerned about the manner in which the Government is responding and not responding to the new nursing home reform law. We believe that this law really represents the direct experiences and concerns of the individuals who live in homes, their families, their advocates, and the public. Based on what all of us have learned over the years about good and bad nursing homes, it is necessary and this law really does reconstruct what nursing home care can be in the United States. If it is implemented correctly, OBRA can really reach the quality of care we would like to achieve.

The Coalition and our member organizations were appalled in 1981, after years of work, by the Federal Government's move to deregulate nursing homes. Congress, in response to this outcry, called for a 10-month moratorium on any regulatory activity by HCFA. HCFA then was directed to go back to the drawing board and work with consumers and providers to develop new information. The Institute of Medicine report, which very shortly thereafter was re-

leased, quantified the concerns of the public about the problems in nursing homes and after the report was issued, rather than let it die, the Coalition called together every major national organization representing consumers, workers in health care, and health care professionals to review and study the contents of the report. In fact, Senator Pryor, in April 1987 you sponsored a briefing to which over 50 national organizations, including providers and consumers, reported their consensus on 12 major issues on public policy addressed by the Institute of Medicine committee.

For the most part OBRA reflects not only the Institute of Medicine recommendations, but the consensus of these 50 national organizations.

As the committee is aware, the remarkable efforts of these groups have continued under something called "Campaign for Quality Care," and have monitored the work of HCFA's implementation. The groups meet monthly and share information about what is going on. On a periodic basis, the campaign members have presented to HCFA our consensus on the issues that have been raised before this committee. Individual HCFA staff have responded positively, but in general, HCFA has refused the consensus of these national organizations on many issues.

We have simply been astounded by HCFA's delays, which have been outlined in all of the testimony today—the delays in providing education, information, and guidance to States on the provisions in the law. We, as you have already stated, are also painfully aware of the confusion, anxiety, and the pushing around of the people who have lived in nursing homes and their families simply because people do not know what to do. There is no clear guidance.

Although States are obligated to implement the law regardless of HCFA's action, the law is complicated and clearly not self-executing, as HCFA claims. It is unbelievable that HCFA would allow the States to flounder with such important issues and programs that we've been dealing with for many years at stake.

It is in this context that we learned HCFA was moving ahead with its own agenda. First, HCFA spent tremendous time and dollars to summarize the 1987-88 nursing home surveys. Although the subject of the reports—public information on nursing homes—is critical and important, this was a project that was done with great speed and with very little participation from the consumers who had been doing this kind of thing for a long time.

The CHAIRMAN. Ms. Rourke, I do apologize, but we're at the 5-minute mark. We will put the remainder of your statement in the record and then we will ask you some questions, if that's permitted.

Ms. ROURKE. I'm sorry. I didn't realize.

The CHAIRMAN. Don't worry about that. Now, you noticed that I did not call time on my colleagues up here, but I do have to call time on the witnesses. [Laughter.]

Ms. ROURKE. I just wanted to summarize with two statements, if I may.

We do, as you know, outline the problems with the content and the process. We really would like to ask the Congress to do two things. The first is to ask HCFA to rescind these proposed requirements, which do not meet OBRA or any other level. The second

issue is really to ask that there be a delay—to intervene in the way you did earlier in 1981—of 12 months or more in the implementation of these 10 dates so that the work can be done properly and we can find funding for those programs.

Thank you very much.

The CHAIRMAN. Thank you, Susan. I think there are about 1.5 million nursing home residents who are glad that you're on their side. Thank you.

[The prepared statement of Ms. Rourke follows:]

TESTIMONY OF SUSAN A. ROURKE, PRESIDENT

NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Federal Implementation of OBRA 1987

Nursing Home Reform Provisions

Before The

SENATE SPECIAL COMMITTEE ON AGING

May 18, 1989

Good Morning. My name is Susan Rourke. I am President of the National Citizens' Coalition for Nursing Home Reform. My testimony will also reflect the views of Citizens' for Better Care, of Detroit, Michigan, a state-wide organization for which I have served as Executive Director for the past 12 years.

We appreciate the opportunity to testify on this important topic. NCCNHR represents over 300 local and state groups throughout the country which are all gravely concerned with the manner in which the government is responding to the new nursing home reform law. We believe that the basic premises of OBRA reflect the direct experiences and concerns of individual and organized nursing home residents, their families, friends, neighbors, and representative organizations, including ombudsman programs. Based on what we have learned about bad, and good, nursing home care during the last twenty years (since Medicaid and Medicare were enacted), it is necessary and timely to reconstruct our nursing home system so that every person residing in a nursing home can receive quality care. If OBRA is implemented correctly, through careful and thorough planning and guidance, we know that this goal will, over time, be accomplished.

NCCNHR and our member organizations long have identified problems in nursing homes. During the 1970's many states moved to change laws to upgrade care; therefore, we were appalled at the federal government's move in 1981 to deregulate nursing homes. Congress, in response to the public outcry, did something unprecedented in nursing home regulation, calling for a ten-month moratorium on any regulatory action by HCFA. HCFA was directed to "go back to the drawing board," and to utilize the experiences of both consumers and providers to come up with a plan for regulatory reform that would meet the public need. Another Congressional action of significance was to persuade HCFA to contract with the Institute of Medicine to conduct its study of nursing home regulation.

The Institute of Medicine report, released in 1986, reflected the public interest. When the report was released, our organization took the lead in an effort to make its progressive and timely recommendations become reality. We called together every major national organization representing consumers, workers, and health care professionals to review and study the contents of the report. You will recall, Senator Pryor, that in April 1987, you sponsored a Congressional briefing, to which over 50 national organizations reported in an unprecedented document laying out consensus on 12 major public policy issues addressed by the IoM Committee. For the most part, OBRA reflects not only the IoM recommendations, but also the consensus positions of these varied national organizations.

As the Committee is aware, the remarkable joint efforts of these organizations, under the banner of a "Campaign for Quality Care," have continued since OBRA was implemented. Representatives from approximately 30 national organizations continue to meet on a monthly basis. Our purpose is to share information and concerns about HCFA's implementation activities. We also have created various subcommittees to work on the primary issues in OBRA such as nurse aide training, preadmission screening, resident assessment and enforcement. On a periodic basis, we have submitted joint ideas and information to HCFA to attempt to persuade it to accept our continuing consensus work, and to respond to our joint concerns.

It is our responsibility to represent residents and families of nursing homes at the national level; therefore, we have an obligation not only to participate, but to monitor and make public, HCFA's public policy and program decisions and activities. Although in the past, we have expressed strong concern about HCFA's actions and inactions, we simply have been astounded by HCFA's delays in providing education, information and guidance to the states on the important, most timely, provisions of the law. Our staff is in daily contact with many state agencies, health care professionals, providers - indeed, all those who will be affected by the new law. We are painfully aware of the confusion, anxiety and even chaos that have been expressed in the field. Not only has there been an absence of official materials on important topics, such as nurse aide training, but the field has received contradictory and incomplete information and guidance on issues such as preadmission screening. Although the states are obligated by OBRA to implement regardless of HCFA action, these provisions of the law are complicated and clearly not self-executing. It is unbelieveable that HCFA would allow the states to flounder with such important issues and programs at stake.

It is in this context that we learned that HCFA was moving ahead with its own time-consuming agenda. First, HCFA spent tremendous agency time, effort, and funds to develop and release summary reports of 1987-88 survey reports. This was done with such force and speed that the agency was not even willing or able to incorporate the ideas and recommendations of the many consumer groups who were asked to respond. Although the subject of the reports - information for citizens to use in selecting a nursing home - is necessary, this is clearly a project which would have had better results if done at another time and with a more open process. Most importantly, this effort, which involved substantial time of key HCFA officials, could have been delayed until after the many 1988-89 Congressional deadlines were met.

Second, we learned that HCFA was also moving full speed ahead to complete a final rule for new "Conditions of Participation," based on the proposed rule of October, 1987, published for public comment shortly before OBRA was enacted. When we learned of HCFA's plans, our Campaign for Quality Care, with co-signers from fifty-one national organizations, wrote then Secretary Otis R. Bowen, urging him to meet with representatives of the Campaign, to hear our concerns about the HCFA Administrator's unpopular and misplaced priorities. In that letter, attached as an exhibit, we urged HHS to issue a new Notice of Proposed Rule Making for full public review and comment; one that would take into account the provisions of OBRA which call for significant strengthening of standards relating to rehabiliative services, nurse staffing, social services and activities, instead of the proposed downgrading which we had seen in a leaked August draft of the final rule.

The Secretary was unresponsive to the Campaign's concerns. In his January 12, 1989 answer, he said that the law would be implemented in stages and that the Department would go ahead with plans for the final rule. He also stressed that proposed rules on nurse aide training and preadmission screening would be published in the early part of 1989 (a plan which has clearly not been fulfilled). Further he rejected the Campaign's recommendation that HCFA establish an advisory committee to help assure an effective and fair implementation process.

When the Campaign groups were able to obtain an unofficial draft copy of the final rule in November 1988, we moved quickly to let HCFA know how dissatsifed, even dismayed, we were with its contents. After considerable insistence, we were able to get Dr. William Roper, HCFA Administrator, to meet with representatives of concerned organizations. Our coalition of groups

included representatives of providers as well as other concerned parties. Although we were able to convince HCFA staff to change some of the draft provisions that contradicted OBRA, we were not able to persuade the agency to delay its publication of the rules. HCFA simply chose, once again, not to listen. On February 2, as you know, HCFA published the Final Rule (with request for public comments) and has clearly indicated the rule will become effective the first of August.

The final rule is important; as we were advised in a meeting with providers of care only yesterday, most providers will look to regulations to see what they should do, not the law. Surveyors will use the rule to determine what to measure. This Rule and these requirements are inadequate.

The Final Rule: Problems and Impact

Even though the rule incorporates some of the new vision fostered by OBRA, important current nursing home services would be weakened severely. The problems with content of the Requirements fall into three areas: (1) areas which are merely a restatement of the law, without necessary regulatory interpretation; (2) areas in which the Requirements specifically undermine OBRA, and, (3) areas in which the Requirements are less than is currently required or in conflict with current law.

(1) OBRA added new provisions for a number of new areas in which states have previously not been regulated and providers have not had to meet standards. In only restating the OBRA language, HCFA offers no guidance to either the states, providers or the public who will be looking for changes as a result of the law.

For example, the law states that a facility is to "assure that all of the residents attain or maintain the highest practicable physical, mental and psychosocial well-being." Should this be tied into the resident assessment and care planning? What benchmarks should there be for determining that a facility is doing everything it can to meet that goal? The Requirements offer little guidance.

How should the home prepare a resident for transfer? A number of states have experience with transfer provisions including counseling of residents; their experiences as well as the extensive research which has been done on transfer trauma over the past 15 years should be used in developing concrete training for staff and procedures for resident counseling. The Requirements do not offer this guidance.

What will be required of a facility in order to meet the mental health needs of the residents, as directed in OBRA? There are several models which have been developed over the past years. They include the staff training consultation model and the direct outreach to residents with resident self referral model. In addition, this issue is not clarified in the face of preadmission screening requirements and the prohibition against nursing homes as Institutions for the Mentally Diseased (IMD). The Requirements do not clarify what is meant or how to do it.

Facilities are not given guidance on providing identical services to residents regardless of the source of payment, an area which is certainly controversial. For example, in the Rule, what is meant by "offering?" Will all services of the nursing home offered to the private pay resident be offered to the Medicaid resident, knowing that the Medicaid resident cannot pay? The Requirements do not help define this issue for homes, residents or the public.

(2) In some areas, the requirements specifically undermine the law. The most glaring of these areas are Social Work Services and Activities. The Requirements offer no clarification on what social services will be required for facilities under 120 beds, and further, the requirements decrease the professional levels of those providing such services. The final rule relates exclusively to the area of quality of life. In fact social services needs are a key component of the resident assessment and treatment plan. Social workers provide mental health services to nursing home residents and provide a link to families and to community resources. The final rule fails to describe the scope of social work services. Additionally, it fails to include the consultation and supervision provisions that were specified in the Conference Report for OBRA.

Social Services takes on increasing importance, as the makeup of the resident population changes in response to the Hospital DRG system and extensive discharge planning becomes a part of the nursing home procedures. Without guidance, smaller nursing homes will not know how to implement a social services program. Without justification, the Requirements also reduce the level of professional training required for social workers in strict conflict with OBRA.

In the area of Activities, the requirement is downgraded and subsumed, just as is Social Work Services, under Quality of Life. While the Activities requirement is clearly important to the quality of living for residents, it

has much more vital significance. The law states that a nursing facility "must provide an on-going activities program, directed by a qualified professional, designed to meet the interests and the physical, mental and psycho-social well being of each resident," emphasizing the important role of activities in day-to-day care.

Activities requirements are also reduced from their importance in OBRA. To maintain quality of life in a facility, more is needed than Bingo. Activity Directors have the ability to assess individual resident skill levels and fit programs to abilities and needs. In addition, good activity programs can and do build on the many years of skills which the residents bring to the facility. In diminishing this provision of OBRA, the Requirements diminish the quality of life for residents.

Social Services and Activity Programs will be key in attaining OBRA's mandate that each resident be provided the necessary services to help attain or maintain the highest level of psychosocial functioning. The Requirements set forth by HCFA fall short of the services intended by Congress.

Indeed, the Requirements for Quality of Life section leaves the main responsiblity to these two disciplines, leaving out nurses, physicians, dieticians, and other important health care professionals. HCFA ignored consensus language offered in official comments by the Campaign for Quality of Care groups. The Quality of Life Requirement published in February needs considerable work before it will provide the guidance necessary for nursing facilities to achieve OBRA's specific mandate that "A facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of <u>each</u> resident."

(3) The new Requirements are in conflict with or fail to meet the standards of existing law. One such problem area for families, residents and advocates is Medicaid Discrimination. The Social Security Act, since 1977, prohibits providers from requiring deposits, gifts or other sums of money as a condition of admission to Medicaid homes. The Requirements state that this will become effective 10/1/90.

These are but a few of the problems with the contents of the February 3, 1989 HCFA Final Rule.

In the hope that we still could influence a more rational behavior HCFA's part, the Campaign for Quality Care quickly put together a letter with 40 co-signers on March 10, directed to the new Secretary Louis Sullivan. (A copy of this letter, and the aforementioned letters, are submitted for the record.) We reviewed the history of HCFA actions and our expressed concerns. We advised Dr. Sullivan that because of HCFA's behavior, "states must implement OBRA provisions that have devastating consequences for individuals without written, legally consistent, and helpful guidance." Furthermore, the Campaign urged Dr. Sullivan to review, and redirect HCFA's response to OBRA.

NCCNHR and many of the Campaign for Quality Care organizations felt that we had to respond to HCFA's February 2, Final Rule with Comments, even though we believe strongly that the Rules are not timely and that they violate the Administrative Procedures Act. The public simply has not had a opportunity to respond to the direction that HCFA is taking on the new reform law. Furthermore, as the Committee has stated so correctly, these regulations on OBRA are not even due until October of 1990. It is true that consumer groups often criticize the government for moving too slowly - as indeed they have on nurse aide training and preadmission screening issues. However, we are just as concerned when the government moves so quickly as to doom important programs to fail for lack of clear, solid direction needed by the states and nursing facilities.

We are absolutely certain that the February 2 Rule should be rescinded, and after more HCFA staff work, be redesignated as a Notice of Proposed Rule Making with a 120 day public comment period. There is no possibility that HCFA can provide the training and guidance necessary for survey agencies to implement this rule - even it were a good one.

This Senate hearing is in keeping with the progressive intervention by Congress in 1981. Congressional concern and a strong message to HHS at that time allowd us eventually to achieve this major reform law. It is appropriate and timely for Congress once again to intervene, perhaps to request that HCFA once again, "go back to the drawing board" with the assistance of all concerned parties. The Campaign for Quality Care has recommended time and time again that HCFA broaden its public participation to include an advisory group which could help assure implementation of OBRA. Drs. Bowen and Roper refused. Secretary Sullivan has not yet answered our March 10 correspondence. Concerned parties need your help in focusing the attention by the new Secretary and the new HCFA Administrator on this critical issue.

We have come too far to accept the irrational, limited manner in which the key government agency has responded to OBRA. We firmly contend that OBRA's outstanding provisions for nursing home reform will not be realized until HCFA develops a rational, responsive plan for its implementation. We all want to work with HCFA. As indicated, the Campaign offered repeatedly to assist HCFA to incorporate all relevant viewpoints, with the primary focus on residents' needs.

The impending chaos in OBRA's implementation by the states causes us to request even more of you. We urge you to stop the monstrous problems being created by the disorganized, often unresponsive, imlementation of this comprehensive legislation. We urge you to enact amendments to the Social Security Act to delay implementation of all requirements with a specific due date, such as nurse aide training, preadmission screening and resident assessment, by a period of at least 12 months. This will allow a planned participatory process that will meet the requirements of OBRA. Additionally it will provide time for Congress and the States to fund OBRA's requirements. At the same time, we ask that you use your authority to redirect HCFA's activities as you did in 1981 so that OBRA indeed will become a reality for our nation's nursing home residents. These changes are particularly important and timely given the change in administration of HHS and HCFA.

National Citizens' Coalition for
NURSING HOME REFORM

Elma Holder, Executive Director
Barbara Frank, Associate Director
Susan Rourke, President

1424 16th Street, N.W.
Suite L2
Washington, DC 20036
202 797-0657

March 10, 1989

The Honorable Louis W. Sullivan, M.D.
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Sullivan:

The organizations that participate in the Campaign for Quality Care congratulate you on your appointment. We take this opportunity to introduce our Campaign and inform you of pressing concerns relating to nursing home regulatory work.

During your tenure as Secretary, the Health Care Financing Administration will develop and implement the most comprehensive and important changes in nursing home regulation in history. Our organizations--which represent consumers of nursing home services, owners, managers, and employees of nursing homes, health care and social services professionals, state regulators, the elderly and disabled, and religious institutions--have worked together since 1983 to bring about these changes. We look forward to working closely with you as HCFA develops regulations to implement the new Title C. Nursing Home Reform of the Social Security Act, enacted in December in the 1987 Omnibus Budget Reconciliation Act (OBRA), and amended in July, 1988.

OBRA is based largely on the 1986 Institute of Medicine study, Improving the Quality of Care in Nursing Homes. Funded by HHS to explore questions of nursing home quality and the regulation of Medicare and Medicaid facilities, the report concluded that the federal government should develop and enforce higher standards. It set forth recommendations for protecting residents' rights, improving qualifications of nursing home personnel, assessing and meeting residents' health and social services needs, and creating more effective enforcement systems. Our groups, which represent virtually every constituent group in the nation concerned about nursing homes, welcomed IoM's recommendations as the basis for reform in the 1980s and 1990s.

Within weeks of the IoM report's release, we began our joint study of the IoM issues and recommendations to determine how they could be put into practice. From a wealth of experience in all phases of nursing home life and management, we achieved consensus on twelve issues which helped Congress focus on nursing home legislation. These important consensus papers and supplemental positions are in the enclosed document, Campaign for Quality Care.

Since the law was enacted, we have continued our commitment to reform by pursuing effective implementation of OBRA, meeting regularly to review HCFA draft materials. On occasion, HCFA has asked representatives of selected organizations to meet. We believe these meetings are essential to developing realistic, effective policies on OBRA regulations and asked HCFA to conduct additional meetings with a broader representation.

We are deeply concerned that regulation of this act has not proceeded in a timely manner and that states must implement OBRA provisions that have devastating consequences for individuals without written, legally consistent, and helpful guidance. Requirements of immediate concern include the training and competency evaluation of nurse aides and pre-admission screening for the appropriate placement of consumers with mental illness and mental retardation. These two issues, and other such as enforcement, merit high priority because of the complexity and scope of the law. Yet the states, facilities, and other affected parties have had to struggle to meet implementation deadlines without full and clear federal guidelines.

For example, on January 1, 1989, states began to screen admissions to nursing homes to determine whether applicants have mental illness, mental retardation or a related condition and whether they will receive the appropriate placement for treatment of their mental condition. HCFA missed its 1988 deadlines for pre-admission screening regulations and minimum standards for appeals procedures for those screened out of nursing homes. The interim draft it circulated for states to use in setting up screening programs conflicted so strongly with OBRA that some states refused to comply and others successfully sought restraining orders to delay compliance. HCFA's own legal counsel has now ordered them to be revised. Our groups hear weekly of persons who have been retained in hospitals or turned away from nursing homes for as little reason as having taken tranquilizers. This is but one problem raised by OBRA's implementation that needs your urgent attention.

Another area of serious concern is a final rule published by HCFA on February 2, 1989, Requirements for Long Term Care Facilities. We have submitted exhaustive comments on drafts of these requirements. Many of our joint recommendations have been discounted, even though HCFA staff have claimed a desire to move forward on areas of consensus. We urged the Department to postpone the development of the rule until other important and more timely work was completed; or, at least, to publish it only as a Notice of Proposed Rulemaking. These "final rules with comment" will implement significant requirements in OBRA next August without consideration of public comments, as required by the Administrative Procedures Act.

The rules are untimely--Congress did not require their publication until October 1, 1990--and impose an unnecessary burden on states already overwhelmed with essential preparatory work on nurse aide training and pre-admission screening. The rules are confusing, with inconsistent effective dates and explicit conflicts with provisions of OBRA, and they fail to provide regulatory interpretation. Although our organizations convinced HCFA to make last-minute changes in the draft rules that removed some contradictions of OBRA's provisions, the final rule still needs substantial revision. We are especially concerned about provisions in these new requirements which will weaken social work services, activities programs and dietary services so important to the well-being of residents.

As the enclosed letters dated February 10, 1988, and November 15, 1988, record, we have expressed our concerns to the offices of the Secretary and the HCFA Administrator, but have received only minimal response.

We continue to maintain that the Department can far more effectively carry out its responsibilities for developing and implementing OBRA's requirements if it fully takes advantage of the Campaign groups' knowledge of how nursing homes are operated, how surveys are carried out and regulations enforced, and how residents are affected by what we do. The Campaign has been steadfast in its effort to achieve agreement on as many workable solutions as possible. We know that the creative energy and collective efforts of government, nursing home providers, health care professionals, consumers and other interested parties will be needed to assure full implementation of the law.

We request that you and the new Administrator of the Health Care Financing Administration meet with representatives from our Campaign for Quality Care as soon as possible to discuss our concerns and our goals for future constructive work.

Even as we bring these problems to your attention, we extend our sincere hope that your term as Secretary will be successful and fulfilling. We trust that efforts to secure increased quality of care for nursing home residents will be a rewarding part of your work.

Sincerely,

Elma L. Holder

Elma L. Holder
Executive Director
NCCNHR

Alzheimer's Association
American Association of Homes for the Aging
American College of Health Care Administrators
American Dental Association
American Dietetic Association
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Nurses' Association
American Occupational Therapy Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society of Consultant Pharmacists
Catholic Charities USA
Gray Panthers
International Association for Enterostomal Therapy
Legislative Coalition for Therapeutic Recreation
Mental Health Law Project
National Alliance for the Mentally Ill
National Association of Activity Professionals
National Association of Boards of Examiners of Nursing Home Administrators
National Association of Counties
National Association of Retired Federal Employees
National Association of Social Workers
National Association of State Long Term Care Ombudsman Programs
National Committee to Preserve Social Security and Medicare
National Consumers League
National Council of Jewish Women
National Council on Aging
National Council of Community Mental Health Centers
National Gerontological Nursing Association
National Hispanic Council on Aging
National Mental Health Association
National Recreation and Park Association
Older Women's League
Presbyterian Church of the USA
Service Employees International Union
The Section for Aging and Long Term Care of the American Hospital Association
United Seniors Health Cooperative
Villers Advocacy Associates

Dr. Bowen's response to 11-15-88 letter from 51 national organizations

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 12 1989

JAN 13 1989

Ms. Elma L. Holder
Executive Director
National Citizens' Coalition
for Nursing Home Reform
1424 16th Street, N.W., Suite L2
Washington, D.C. 20036

Dear Ms. Holder:

I am responding to your letter of November 15 asking me to establish an Advisory Committee on Nursing Home Reform and expressing concerns about Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) implementation by this Department. I am sorry for the delay in responding to your letter.

I understand that Dr. Roper met on December 16 with representatives of your organization as well as with representatives of other consumer and provider organizations. Although there were differences over some of the issues, the meeting produced a clear understanding of your position and those of the provider community.

As I hope is clear now, we will be implementing P.L. 100-203 in stages. The first stage will be the publication of the requirements for long-term care (LTC) facilities. This regulation will finalize the proposed rule that we published in the Federal Register on October 16, 1987, at 52 FR 38582, and will implement nearly all of the P.L. 100-203 provisions that apply directly to LTC facilities (i.e., requirements). This regulation will be published as a final with comment which will mean that the regulations will be applicable, but your organization will have an opportunity to comment and suggest changes to any objectionable provisions.

The second stage will be a proposed rule on P.L. 100-203 provisions which are not directly applicable to LTC facilities, but are responsibilities of the Federal and State governments (for example, nurse aide training, and preadmission screening for the mentally retarded and mentally ill). We expect to publish this proposed rule in the early part of 1989.

The last stage will be to develop a final regulation for both the requirements (if this proves necessary) and all other provisions of P.L. 100-203. We hope to accomplish that in the latter part of 1989. In the meantime, we are implementing many P.L. 100-203 provisions through administrative action. We believe this plan of action will give nursing

home residents important health and safety protection while resolution of some stubborn issues is addressed. It will also make for an orderly transition from existing regulations to complete P.L. 100-203 implementation by October 1, 1990.

The publication of the Health Care Financing Administration's nursing home survey information was released on December 1, 1988. I am comfortable with the quality of the data presented in it.

Regarding your advisory proposal, I do not think that it would be advisable for me to establish an Advisory Committee on Nursing Home Reform at this time. Prior to the development of the proposed rule to reform nursing home standards, we contracted with the Institute of Medicine which provided us with a report entitled "Improving the Quality of Care in Nursing Homes." We carefully followed that report in proposing rules for LTC last October, and Congress looked to the report in crafting the changes in P.L. 100-203. To establish such an advisory committee at this time would be time consuming and duplicative in view of the clear direction we have received.

Thank you for your concern and assistance in implementing nursing home reform.

Sincerely,

Otis R. Bowen, M.D.
Secretary

National Citizens' Coalition for
NURSING HOME REFORM

Elma Holder, Executive Director
Barbara Frank, Associate Director
Susan Reverby, President

1424 16th Street, N.W.
Suite L2
Washington, DC 20036
202-797-0657

November 15, 1988

The Honorable Otis R. Bowen
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Bowen:

We are a coalition of 51 national organizations dedicated to achieving a smooth, effective and meaningful implementation of the Nursing Home Reform Amendments in the 1987 Omnibus Budget Reconciliation Act, P.L. 100-203. We are writing to request a meeting with you to discuss implementation of OBRA, based on our concerns about the proposed final draft of the Conditions of Participation and other issues presented in this letter.

We have worked cooperatively and diligently to achieve our common goal - high quality care and quality of life for this nation's nursing home residents - through new standards of care, an improved survey system and stronger mechanisms for enforcement of those standards.

The new law reflects the findings of the Committee on Nursing Home Regulation of the Institute of Medicine, appeals court decisions in the Smith v. Bowen case and subsequent orders of the federal district court, as well as numerous congressional hearings and a broad-based public consensus developed by our coalition and published in April, 1987, as the Campaign for Quality Care in Nursing Homes. It represents a 15-year effort for better protection and service for our citizens who live in nursing homes.

We understand fully how difficult it is to develop the important regulations for OBRA, especially those relating to residents' rights, quality of life, resident assessment, quality of care, nurse aide training and pre-admission screening. On a few occasions over the last few months, HCFA has held a meeting in which limited numbers of individuals were asked to review preliminary drafts of HCFA's work. We appreciated these meetings and responded to this task as energetically as possible given the time constraints we are all working under to implement OBRA in a timely manner. Still, we must express our concerns with both the process and the outcome of this work. The meetings were not always representative of consumers, providers, or health care professionals and other employees appropriate to involve. The drafts, which we understand are nearing completion, do not provide the extent or quality of guidance needed by the states and providers; nor do they meet the public's expectations regarding implementation of new programs.

In view of the magnitude of the issues and the regulatory tasks before us, we urge you to meet with us to plan how the work is to be accomplished so that our mutual goals are accomplished effectively and efficiently. We believe it is then appropriate and necessary for the Department to establish an Advisory Committee on Nursing Home Reform. This would accomplish numerous desirable goals: (1) It would bring together concerned parties on an ongoing basis for full participation in development of the regulations; (2) It would provide a forum for exchange of ideas; (3) It would eliminate unnecessary lost time by addressing serious concerns of the various parties early on and with full participation by all; and (4) It would help assure the Department that the final draft of implementing regulations would have broad-based support from the most affected constituencies.

Of most immediate concern are the guidelines for nurse aide training and for pre-admission screening for mentally ill and mentally retarded individuals. Implementation of these two new and important programs requires significant direction to the states in order to achieve congressional intent. The direction suggested by the most recent drafts of HCFA documents falls far short of what is needed. Neither proposal appears to meet the spirit or the letter of the law. We are concerned that, if implemented in current form, the programs would result in harm to many beneficiaries, rather than the increased care and protections which were intended.

As we expressed in previous correspondence, we are concerned about the quality and timeliness of HCFA's proposed publication of nursing home survey information. The survey summaries accidentally released and circulated in September confirmed our opinions that the information is still confusing, sometimes contradictory or incomplete and of little value to individual citizens or others, as presented.

We applaud HCFA's desire to get more and better information for consumers to use in selecting a nursing home and for public policy work. In the next several months, we would like the opportunity to work with HCFA staff on improvements in the document - before it is released to the general public. Furthermore, since the resources of the federal and state survey programs are already stretched to the limit, we urge the Department to focus its resources on implementation of the many complicated pieces of OBRA which will, in the long run, improve the system from which survey information comes.

Additionally, it is our belief that although the new Conditions of Participation are said to implement provisions of OBRA, significant work is needed to accomplish that goal. In order to implement OBRA, we urge HHS to issue a new NPRM for full public review and comment. For example, the NPRM should take into account provisions in OBRA which call for significant strengthening of standards relating to rehabilitative services, nurse staffing, social services and activities, instead of the proposed downgrading contained in the August draft final Conditions of Participation.

Because of these important issues and our concerns regarding them, it is extremely important to meet with your designated staff and other staff providing leadership on OBRA implementation. We ask that Dr. Roper, Mr. Morford, Dr. Smith, Mr. Hoyer, Ms. Fredeking and Mr. Friedlaeb be present at this meeting, as well as others you consider appropriate.

We are available to meet at your convenience between November 28 and December 5, 1988, with at least 15 of our representatives present. We eagerly await a positive response to our request.

Sincerely yours,

Elma L. Holder

Elma L. Holder, Executive Director
National Citizens' Coalition for Nursing Home Refo

Alzheimer's Association
American Association of Homes for the Aging
ABA's Commission on Legal Problems of the Elderly
American Dental Association
American Dietetic Association
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Jewish Congress
American Nurses' Association
American Occupational Therapy Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society of Consultant Pharmacists
Association of Health Facility Licensing and Certification Directors
Catholic Charities, USA
Catholic Health Association
Consumer Federation of America
Gray Panthers

Mental Health Law Project
National Alliance for the Mentally Ill
National Association of Area Agencies on Aging
National Association of Activity Professionals
National Association of Counties
National Association of Protection and Advocacy Systems, Inc.
National Association of Retired Federal Employees
National Association of Social Workers
National Association of State Long Term Care Ombudsman Programs
National Association of the Deaf
National Association of Boards of Examiners for Nursing Home Administrators
National Caucus and Center on Black Aged
National Coalition of Resident Councils
National Committee to Preserve Social Security and Medicare
National Consumers League
National Council of Jewish Women
National Council of Senior Citizens
National Council on the Aging
National Council of Community Mental Health Centers
National Gerontological Nursing Association
National Hispanic Council on Aging
National Mental Health Association
National Pacific-Asian Resource Center on Aging
National Recreation and Park Association
National Therapeutic Recreation Society
National Union of Hospital and Health Care Employees, AFL-CIO
Older Women's League
Presbyterian Church of the USA
Service Employees International Union
United Seniors Health Cooperative
Villers Advocacy Association

cc: Dr. William Roper
Mr. Thomas Morford
Dr. Wayne Smith
Mr. Thomas Hoyer
Ms. Helene Fredeking
Mr. Alan Friedloeb
Sen. Lloyd Bentsen
Sen. John Heinz
Sen. George Mitchell
Sen. David Pryor
Rep. John Dingell
Rep. Claude Pepper
Rep. Edward Roybal
Rep. Fortney Stark
Rep. Henry Waxman

The CHAIRMAN. Bruce Spitz, with the American Red Cross. Bruce, before you make your statement, our ranking member, Senator Heinz has now gotten back from the Finance Committee.

Senator Heinz, would you have an opening statement?

STATEMENT OF SENATOR JOHN HEINZ

Senator HEINZ. Mr. Chairman, I do have an opening statement but for the purposes of conserving time, I'd ask unanimous consent that it be placed in the record in its entirety.

The CHAIRMAN. The statement will be placed in the record.

[The prepared statement of Senator Heinz follows:]

STATEMENT OF SENATOR JOHN HEINZ
RANKING MEMBER, SENATE SPECIAL COMMITTEE ON AGING
"Implementation of OBRA '87 Nursing Home Reform"
May 18, 1989

The road to nursing home reform has been a long and rocky one. Six years of hearings and investigations I conducted, as Chairman of this Committee showed the air had gone out of what little quality initiatives existed from the 1970s and America was left with a deadly flat tire in our drive for reform. The passage of the nursing home reforms under the Omnibus Reconciliation Act of 1987 marked a significant milepost in our struggle to assure this nation's oldest, sickest citizens adequate, decent care.

The purpose of the OBRA nursing home provisions is to first, improve the quality of care and quality of life in nursing homes; and second, to create a strong, effective enforcement system to ensure that substandard care is met with appropriate and swift penalties. We must not lose sight of this purpose - we have worked too hard and too long to let these reforms fall by the wayside.

Statistics and studies tell us we need now - - more than ever - - to take steps to ensure quality in our nation's nursing homes. The sheer demand for nursing home services will grow by almost 30% in the next decade - - an increase of 7 to 9 million. Quality problems still exist in nursing homes nationwide. A Health Care Financing Administration (HCFA) report, released in December 1988, for example, revealed that 25% of nursing homes nationwide failed to give drugs according to doctor's orders and 45% did not prepare or serve food under sanitary conditions.

What we are hearing from states, providers, and residents alike is that the process of implementing the law may be the undoing of Congressional intent. The most pressing problem seems to be the timeframe and manner in which HCFA has chosen to implement this complex law. Other problems include the lack of consistent guidance on such crucial issues as pre-admission screening for mentally ill and mentally retarded persons; and nurse aid training. Even Pennsylvania which started quality assurance programs before the nursing home reforms were enacted, is having problems meeting HCFA's deadlines.

My concern 6 years ago was that bed board and abuse had replaced quality care in America's nursing homes. Today, my concern is that a lax and lame bureaucracy will undermine quality reform.

I hope from this hearing we can find a workable solution that will enable states, providers and HCFA to work together to make sure that the nursing home reforms are effectively implemented. Let's not let process tear down a good law that took eight years to build.

Senator HEINZ. Mr. Chairman, in addition to the Finance Committee, I also am ranking on the Securities Subcommittee at Banking. Senator Dodd, who has another hearing himself, has asked me to go up there later on and help co-chair that hearing. So, I apologize to you and to our witnesses for any jack-in-the-box behavior that I may be exhibiting.

The CHAIRMAN. We all understand. Thank you, Senator Heinz. Bruce Spitz.

STATEMENT OF BRUCE SPITZ, DIRECTOR OF SPECIAL PROJECTS, AMERICAN RED CROSS

Mr. SPITZ. Thank you, Mr. Chairman. We do have a written statement that we would like placed in the record. It is a lengthy statement and I will not bother reading all of that statement to you.

The CHAIRMAN. The full statement will be placed in the record.

Mr. SPITZ. Thank you very much.

I am here today to speak for the American Red Cross on the implementation of the Omnibus Budget Reconciliation Act of 1987, specifically with regard to nurse assistant training provisions.

I would like to start out by saying that it is rare that the American Red Cross testifies before Congressional committees. We are limited somewhat by our international charter and our mission to avoid political controversies and issues, but we do get involved when we think there's an opportunity to alleviate human suffering and when the health and safety of residents of nursing homes are threatened.

We're concerned that the failure of HCFA to implement OBRA will lead to nurse assistant training that will not meet the requirements that were intended by the Congress, and will not substantially improve training of nurse assistants, nor the quality of care provided by nurse assistants who provide about 80 percent of the care that is given to residents in nursing homes.

We're also concerned as an organization that because of the lack of clarity in the regulations the American Red Cross will be prohibited from delivering its training program in certain States and that reimbursement policies in those States will make any adequate training impossible. The net result of all that will be poor quality of care.

Our organization trains about 7 million every year, primarily in first aid, CPR, and water safety training, but also in programs for child care workers, nurse assistant training, home health aides, and other areas. We have about 150,000 instructors and we've been doing it for many years. We have put together a course that we believe is the standard of the industry that relies on many of the other courses that have already been produced. We're proud of that course and we would like to see it implemented.

I will not go into the details of those materials other than to say that they have been field tested and we believe we have developed the only national nurse assistant training program of its type in the country. However, there are a number of issues in getting that program implemented.

First, we've sought implementation of our program in 48 States to date. What we've discovered is that about 18 of these States don't have a process in place or are not ready to even review our materials. Many States that are reviewing our materials aren't sure how they're going to implement this program. In a number of States, four in particular, we've been told that we can't even implement our program because the State is only going to have one program and it is going to be implemented through a State system. In four States as of today, we've been told that we can provide our training.

It is very clear to us that there is no pattern, there is no common signal that has gone to States, and there's a great deal of confusion in those States about how this training is to be done. It is a major concern for us because we have a program that we believe has to be put in place by the end of this year if we're going to meet the requirements of OBRA.

Another major issue that we've run into is the reimbursement question. We've looked at a number of States, at their reimbursement policies, their current policies, and proposed policies under OBRA. What we've discovered in that procedure is that reimbursement ranges from $3.33 a hour for a student to $0.48 a hour for a student. We wonder how States are planning on training qualified nurse assistants when they're going to reimburse at that level. We have come up with a series of recommendations to address this inadequate training. They are in the record.

There is one other point I would like to deal with and that is the question of CPR training.

The CPR issue is one that we have requested be included as a requirement. We believe that it is important that residents be able to receive cardiopulmonary resuscitation when they desire it and that it needs to be available.

Thank you very much.

[The prepared statement of Mr. Spitz follows:]

TESTIMONY OF THE AMERICAN RED CROSS
REGARDING THE IMPLEMENTATION OF
OBRA NURSE ASSISTANT TRAINING PROVISIONS

MAY 18, 1989

INTRODUCTION

Mr. Chairman, I am Bruce Spitz, Director of Special Projects for the American Red Cross. I am here today to testify on the implementation of the Omnibus Budget Reconciliation Act of 1987 and specifically to provisions that pertain to the training of nurse assistants.

The Red Cross is concerned that the federal and state implementation of OBRA will not lead to a training program that will meet the intent of Congress and will not substantially improve the training of nurse assistants nor the quality of care delivered. We are also concerned that we will be excluded as a provider of this important training service by states that refuse to permit anyone other than state sponsored schools to train nurse assistants or by inadequate reimbursement policies that will almost assuredly produce poor quality training.

THE RED CROSS: BACKGROUND

The American Red Cross is a multipurpose voluntary health and social welfare organization. It provides human services in the United States through chapters, regional blood centers, and worldwide through field stations on military installations.

Among the missions of the Red Cross are the improvement of the quality of human life and enhancement of individual self-reliance and concern for others. The Red Cross helps people avoid, prepare for, and cope with emergencies through services that are governed and directed by volunteers. These services are consistent with the Congressional charter and international principles of the Red Cross.

To accomplish its aims, the Red Cross maintains a system of local, national, and international disaster preparedness and relief; provides voluntary blood services to a large segment of the American people; helps individuals acquire the knowledge, skills, and attitudes for a safe and healthy lifestyle through a wide array of health and safety programs and services; provides educational opportunities and volunteer experience for youth; serves as an independent medium of voluntary relief and communication between the American people and their Armed Forces; and assists the government of the United States in meeting humanitarian treaty commitments.

The Red Cross provides human services in the United States through 2,853 chapters and 57 regional blood centers, and worldwide through approximately 300 field stations on military installations. Red Cross funding comes from two primary sources, public support and revenue. Public support represents contributions received directly from the public and indirectly through federated fundraising organizations. Revenues are derived largely from the cost recovery of active program service initiatives such as blood services, restricted grants and contracts, or health and safety courses.

The development, administration, and delivery of new and existing Red Cross programs takes place on three levels: National Headquarters, Operational Headquarters, and local chapters. The National Headquarters in Washington, D.C. is responsible for two main areas: operations and development. Operational support comprises a variety of administrative services that facilitate the provision of service at the local level. Development activities include program development, program evaluation, and program dissemination.

The Red Cross volunteer Board of Governors formulates national corporate policy, and each local chapter and Blood Services region volunteer board of directors decides the best use of the funds and operation assets available for daily operations. These local boards of directors are responsible for meeting the needs of their local communities. Such decentralized rendering of services, combined with centralized policy and control guidance, enables the Red Cross to give prompt, efficient assistance on a global basis.

In March 1988, the Red Cross began to develop a Nurse Assistant Training Program under an agreement with Beverly Enterprises, Inc.

NURSE ASSISTANT TRAINING

The American Red Cross Nurse Assistant Training course is designed to be taught in 84 hours, or 60 hours of classroom and 24 hours of supervised clinical experience. The classroom hours have been divided to include 40 hours of information and 20 hours of skills demonstration. As it stands our course content meets the proposed federal requirements and exceeds the number of hours by nine. We are prepared to augment the curriculum with additional information, skills or clinical hours as needed to meet specific state requirements.

The American Red Cross Nurse Assistant Training Course has a unique philosophy which incorporates six principles of care throughout the manual (infection control, safety, communication, privacy, dignity and independence). To successfully complete the skills component of the course, students must implement all six principles of care with each skill they perform.

Description

Our course will train students to provide quality care and increase their awareness about working with people in long-term care. In addition, students will learn the importance of maintaining the residents' self-esteem while enhancing their own because they are doing their job well.

Using experiential learning, students will be active participants in the learning process. They are also given many opportunities to share their feelings about their role as nurse assistants, take part in various learning activities, practice skills and ask questions.

The skills portion of the program consists of three components: ***Preparation,*** which includes all of the activities necessary for planning care; ***Procedure,*** which includes performing the skill with 100% accuracy; and ***Closure,*** which includes completing the plan of care. This design of care enables the nurse assistant and the resident to feel good about themselves and the quality of care.

Course Components

The Nurse Assistant Training Course employs five basic educational techniques:
Activities
Video
Demonstrations
Practice sessions
Clinical practicum

1. Activities—The structured learning experiences used in this course are intended to stimulate and actively involve students in the learning process.
2. Video—Videos are used to provide model demonstrations of the skills and help ensure standardization of quality wherever the course is taught.
3. Demonstrations—Following the video, instructors will conduct a model demonstration for the class. This demonstration incorporates the six principles of care and provides detailed information about how the skill must be performed.
4. Student Practice Sessions—Practice sessions are part of the classroom component. These sessions allow students to practice each skill prior to entering into the clinical experience.
5. Clinical Experience—Students in this course must spend a minimum of 24 hours in a long-term care facility. Clinical practice time may be expanded to specifically meet the state's clinical requirements.

In order to receive a course completion certificate, students must demonstrate 100% mastery of all skills and pass a written test with a minimum score of 80%.

The recommended class size is 15 students with an instructor/student ratio of 1:5. This ratio encourages the student interaction and discussion essential to adult learning.

The course is taught by RN instructors who are trained and certified by the Red Cross and meet both state and federal requirements.

Review Materials

One feature of the OBRA legislation requires that all currently employed nurse assistants must pass state competency evaluations between July 1, 1989 and December 31, 1989 in order to continue working in nursing homes. The Red Cross is currently preparing three separate, related course review items: a Review Manual, sample test and Facilitation Guide.

1. We are in the process of developing a Nurse Assistant Training Review Manual to assist nurse assistants prepare for competency evaluations. This manual will provide a summary of skill and information sheets that correspond to the Nurse Assistant Training Program materials. This illustrated summary document can be provided to nursing homes who desire to upgrade the skills of current staff and assist them in preparing for competency evaluations.
2. Under an agreement with the Psychological Corporation, the Red Cross can provide self-administered and scored sample competency evaluations to any interested nursing home. Tests will be available later this year in time to assist nurse assistants preparing for this important exam. Approximately 20,000 Beverly nurse assistants will be receiving these tests.
3. A Facilitation Guide is in the process of being developed to support the use of the sample test and Review Manual. The Red Cross intends to train a group of 60 Directors of Nursing and Staff Development from Beverly later this summer using this guide.

We have attached to these written remarks a detailed outline of the Nurse Assistant Training course content, instructor requirements, and specific information on the review and field test process. I believe a review of these materials will demonstrate that the course produced by the Red Cross is a standard of excellence for the field.

TRAINING ISSUES

Upon completion of program field test in January of this year, the Red Cross began the process of seeking state approval for this course. Our experience has demonstrated the state of uncertainty and unpreparedness that exists regarding training in many states.

State Inaction

We have been actively seeking approval in 48 states. As of May 1,1989, 18 states (or 38 percent of the states contacted) had no process of state approval in place for nurse assistant training or were not ready to conduct a review of the Red Cross program. See Table 1.

In addition, four states--Idaho, Kansas, Missouri, and New Jersey--have notified the Red Cross that they do not intend to permit any program other than the one currently approved in that state to be used. In addition, it is clear in these states that most, if not all, training will be done through state sponsored educational institutions. Several other states have indicated a preference or inclination to pursue a similar strategy. In 15 other states we are in varying stages of the review and approval process. Four states have approved our program.

Almost universally we hear the same comments from states.

- -They are unsure of what is expected of them because clear regulations have not been issued.
- -They are unclear regarding reimbursement for this training and are reluctant to proceed until it is clear that payment will be made.
- -They do not, for the most part, intend to change programs where they exist and are reluctant to establish new programs without regulations in place.

The net effect of this response has been most disconcerting to us. It has been difficult, if not impossible, to plan for the implementation of a nation-wide program later this year. Such a program will be necessary if we are to meet the training demands of our largest customer, Beverly Enterprises, and hundreds of other nursing homes across the nation. Planning is not possible without a clear and understandable process of state approval and competency evaluation. If we cannot be counted on as a state approved provided of training, the industry will be forced to seek alternative training providers.

Many of theses providers will not provide adequate training based on our review of the alternatives available.

Table 1
American Red Cross:
Status of Training Process
By State As of May 1, 1989
(48 States)

Approved (4)	Reviewing or Pending Review (22)	No Process or Incomplete Process (18)	Will Not Consider Because of Other State Programs (4)
California	Alabama	Arizona	Idaho
Louisiana	Connecticut	Arkansas	Kansas
Maryland	Florida	Colorado	Missouri
Montana	Illinois	Delaware	New Jersey
	Maine	Georgia	
	Michigan	Indiana	
	Nebraska	Iowa	
	New Hampshire	Kentucky	
	New Mexico	Massachusetts	
	New York	Minnesota	
	Oregon	Mississippi	
	Pennsylvania	Nevada	
	South Carolina	North Carolina	
	South Dakota	North Dakota	
	Tennessee	Ohio	
	Texas	Oklahoma	
	Utah	Rhode Island	
	Vermont	Virginia	
	Washington		
	West Virginia		
	Wisconsin		
	Wyoming		

Lack of Reimbursement

One key variable in training quality is related to the reimbursement of training staff and the ratio of staff to students. A survey of the few states that were able to identify or estimate current reimbursement rates for nurse assistant training (primarily under Medicaid) yields discouraging implications for quality. See Table 2.

Table 2
Estimated Medicaid Reimbursement
For Current Nurse Assistant Training
In Selected States
(Not Including Wages or Benefits)

State	Per Person	Per Hour
California (150 hours)	$500	$3.33
Indiana (108 hours)	50	48
Iowa (60 hours)	70-100	1.17-1.67
Illinois (120 hours)	300	2.50
Minnesota (40 hours)	125	3.13
Nebraska (30 hours)	50	1.67
Texas (75 hours)	110*	1.47

Of seven states identified, the current reimbursement for nurse assistant training varies from $3.33 per hour in California to $.48 per hour in Indiana and $1.17 in Texas. Courses taught at the lower end of this price range cannot result in quality training unless significant subsidies are being provided. At $1.00 per hour it would be difficult to pay the wages of an RN instructor if there were 12-15 students in a class. This does not include materials or text books. Even with this single instructor, student instructor ratios for skills practice and clinical practicum hours would be unacceptable by any standard. We estimate that even in the lowest wage states if a ratio of one-to-five is established for clinical practice and practicum hours that it would cost any provider of training at least $2.25 to $2.50 per hour to deliver a program to meet the minimal standard set forth in OBRA.

* Proposed under OBRA.

Inadequate Training

This concern for quality is magnified when we review state intentions with regard to training standards proposed under OBRA. Based on our research, at least 23 states have defined the total number and ratio of hours between classroom and clinical portions of the course. See Table 3.

Table 3
Review of State Training Requirements
That Further Define OBRA Minimum Requirements

State	Total Hours	Classroom	(%)	Clinical	(%)
Arkansas	75	25	(33)	50	(67)
California	150	50	(33)	100	(67)
Connecticut	75	25	(33)	50	(67)
Delaware	75	37.5	(50)	37.5	(50)
Illinois	120	80	(67)	40	(33)
Indiana	105	30	(29)	75	(71)
Kansas	90	45	(50)	45	(50)
Kentucky	75	45	(60)	30	(40)
Louisiana	80	40	(50)	40	(50)
Maine	150	70	(47)	80	(53)
Maryland	75	37.5	(50)	37.5	(50)
Michigan	75	<=37.5	(50)	=>37.5	(50)
Minnesota	75	=>30	(50)	=>30	(50)
Mississippi	80	40	(50)	40	(50)
New Hampshire	100	40	(50)	40	(50)
New Jersey	90	45	(50)	45	(50)
New Mexico	84	40	(50)	45	(50)
New York	120	90	(75)	30	(25)
Oregon	100	60	(60)	40	(40)
South Carolina	80	40	(50)	40	(50)
Tennessee	100	40	(40)	60	(60)
Utah	80[1]				
Wisconsin	75	=>30	(50)	=>30	(50)

In brief summary, of the states with the minimum 75 hours of training slightly less than half (35) of these hours are spent in the classroom. The American Red Cross is deeply concerned that in many, if not most states, nurse assistants will receive approximately 35 hours of classroom training in total. Based on our field test of the American Red Cross Nurse Assistant Training Program, this is simply not sufficient time to learn the basic skills necessary to be a nurse assistant. If one accepts the compelling logic that the quality of nursing care can only be improved through a better understanding of psycho-social issues, it is imperative that more hours be devoted to basic classroom activities. The Red Cross course follows the pattern set by states like California, Washington, New York, Illinois, Oregon and Missouri by increasing classroom instruction hours to provide a greater

[1] At discretion of facility.

opportunity for students to learn the art of caring. If the pattern of less than one week of classroom training is followed, skills may be learned, but the quality of resident's lives will be uneffected.

CPR Training

A final compounding factor is the inclusion of cardiopulminary resuscitation (CPR) in the State Operations Manual issued by HCFA last month. The Red Cross applauds HCFA for its objective of providing CPR to residents. We believe that every American has the right to be resuscitated if it is done properly and with the individuals permission. While nursing homes may be required to follow a resident's wishes not to be resuscitated, they should be able to respond to a resident's emergency needs until a nurse or other person trained in CPR arrives.

With the addition of CPR to the mandatory curriculum, the demand for expanded classroom training is even more evident. Our experience shows, that the most difficult skills a nurse assistant will learn will be those associated with CPR. While a minimum of 4 hours of instruction is required to learn CPR skills, based on our experience nurse assistants may require even longer training.

Recommendations

Based on our analysis and experience we recommend the following provisions be considered:

1. Require states to approve nurse assistant training programs by qualified providers, such as the American Red Cross, who meet all federal and state criteria with regard to course content and instructor qualifications.

2. At least 50 hours of the training required should be devoted to classroom instruction and skills demonstration with the remaining hours devoted to the application of skills and knowledge within the clinical setting.

3. Instructor to student ratios within the range of one to five should be established for skills demonstration and clinical practice portions of the training program.

4. All skills demonstrations and clinical practice elements should be taught by trained instructors who meet all federal and state requirements, reside on location and have successfully completed an approved train the trainer program.

5. A minimum of four additional classroom hours should be added to the 75-hour requirement to permit the inclusion of CPR training.

6. Adequate reimbursement should be provided to permit states to comply with instructor qualification criteria, support a ratio of one instructor to five students for skills demonstration and clinical practice portions of the training, and cover costs of materials and text books.

Nurse Assistant Training Course

Course Description

This packet contains:

- Introduction
- Course Overview
- Course Structure and Format
- Course Instructors
- Course Objectives
- Course Outline
- Course Development Milestones
- List of Project Team Members
- List of Advisory Committee Members
- List of Expert Panel of Reviewers

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Introduction

The American Red Cross, an organization with a long-standing tradition in nursing and health education, is developing a national Nurse Assistant Training Course. This course will provide comprehensive training to those who care for the frail elderly and disabled residents of nursing homes throughout the nation. Support for this effort is provided by Beverly Enterprises, the nation's largest provider of long-term care.

The course will be delivered nationally through the Red Cross network of chapters and will assure compliance with federal and state nurse assistant training requirements. Additional modules will be specially designed to meet specific state requirements where appropriate. Integrated throughout the basic course is a Red Cross philosophy of care. That philosophy should enable each student to understand the importance of their contribution to the quality of life for residents in long-term care. It is our hope that this course will improve the quality of resident care throughout the nursing home industry.

A draft of the course was completed in July 1988 and reviewed by an advisory committee as well as a panel of expert reviewers. A revised version of the course was piloted in seven sites across the country in January and February 1989.

Based on the results of the pilot test, the course is being finalized and will be made available by late summer, 1989.

Course Overview

Each morning over one million people begin their day in long-term care facilities; many will stay only long enough for recovery and/or rehabilitation; others will live out their lives there. The quality of a resident's life while in long-term care is largely determined by the quality of care provided by the nurse assistant. Eighty percent of a resident's day is spent with the nurse assistant; the nature of the nursing care a resident receives during that time, as well as the nature of the interaction between residents and nurse assistants, can be enhanced with a comprehensive training program. The American Red Cross Nurse Assistant Training Course is designed to enhance both the ability and the desire of nurse assistants to provide quality care.

The Nurse Assistant Training Course is an 84-hour course, which includes 60 hours of information and skills demonstration in the classroom and 24 hours in a supervised clinical experience. Additional classroom and clinical modules will be developed to meet specific state requirements beyond 84 hours.

The classroom portion of the course includes the following 19 units:

- **Orientation**
- **Understanding Residents in Long-term Care**
- **Understanding the Rights of Residents in Long-term Care**
- **The Role of the Nurse Assistant**
- **Maintaining Infection Control**
- **Following Safety and Emergency Procedures**
- **Understanding the Aging Process**
- **Taking and Recording Vital Signs**
- **Admitting, Discharging, and Transferring Residents**
- **Assisting With Positioning and Moving**
- **Maintaining Residents' Environment**
- **Assisting Residents With Personal Care**
- **Assisting Residents With Nutrition**
- **Assisting Residents With Elimination**
- **Modifying Care for Residents With Special Needs**
- **Supporting Residents and Families Through Death and Dying**
- **Restorative Nursing**
- **Assessment, Care Planning, and Organizing Work Effectively**
- **Closure**

In the classroom, under the direction of a registered nurse instructor, students will learn new information, explore their attitudes, and practice skills needed to perform their duties as nurse assistants. Students will be expected to demonstrate 100 percent mastery of skills and 80 percent mastery of information in order to successfully complete the classroom portion of the course. The integrated clinical experience will allow them to put their learning into practice under the supervision of a nurse in a long-term care facility.

Throughout the classroom and clinical components, the overarching goals of the course are:

- to teach the information and skills that will give nurse assistants the *ability* to provide quality nursing care; and
- to create a positive, nurturing attitude toward elderly and disabled residents that will increase nurse assistants' *desire* to provide quality care.

The structure, format and content of the Nurse Assistant Training Course have been carefully designed to facilitate the achievement of these goals.

Course Structure and Format

As previously indicated, the classroom instruction portion of this course consists of 19 units. Each unit consists of one or more modules; a module includes the following components:

Preliminary Instructor Information

- **Module cover sheet** serves as a table of contents for the module and indicates the minimum amount of time required to teach the module.
- **Instructor preparation guidelines** list the materials needed to teach the modules and actions that should be taken to prepare for the module.
- **Student learning objectives** identify what students will learn during the module.
- **Key concepts** are the major conceptual points that must be made and emphasized while teaching the module.

Lesson Plan

- **Definitions** refer to medical words in the lesson plan that must be defined in lay terms as they come up in the text.
- **Introduction** to the module provides an overview of what will be covered in the module and suggestions for introducing the material.
- **Information** covers content that students need to know in order to perform responsibly in their role as a nurse assistant.

- **Feelings and Attitudes** provide talking points to help involve students in a discussion about their feelings and any concerns they have about the skill or information being learned.

- **Skills** (for nursing modules) are clinical skills taught using a four-step methodology. First, the skill is viewed on video and any questions that arise are answered. Second, the same skill is demonstrated by the instructor who can "stop action" at any point to explain a step in the procedure. Third, students practice the skill using an illustrated skill sheet. Fourth, the students are evaluated by the instructor as they perform the skill.

- **Activities** (for psychosocial modules) are structured learning activities (e.g., role plays, small group tasks) designed to help students learn by doing.

Supplementary Materials

- **Work sheets** for students supplement the learning activities and give students information they need in order to participate in the experiential learning activities and discussions. They also provide general reference information.

- **Instructor resources** provide information that is not included in the content of a module but is needed by the instructor to teach a skill or conduct an activity.

- **Skill sheets** are intended to be used by the students as they learn and practice a skill. They explain the preparation, procedure, and closure steps for each clinical skill and provide illustrations of steps in a skill's execution. There is a place indicated on the skill sheets to evaluate students' competency on a given skill.

Course Instructors

The classroom portion of the course will be supervised and taught by registered nurses. In addition, instructors will be assisted by other licensed nurses and health care practitioners in the skills practice and clinical components of the course. The clinical practicum in the course will be supervised by a registered nurse.

Instructors for this course will be Red Cross prepared instructors who have completed:

- Introduction to Health Services Education training, which prepares trainers in adult education theory and practice, and

- Eight days of training as instructors for the Nurse Assistant Training Course.

In addition:

- R.N. instructors will be required to meet federal and state educational and experience standards.

- Assisting instructors will be licensed nurses, physical therapists, registered dieticians or social workers who are experienced and proficient in the skills taught in the course.

Course Objectives

- To enable nurse assistants to improve the quality of life for residents in long-term care
- To enable nurse assistants to provide basic nursing care
- To enable nurse assistants to maximize and maintain residents' independent functioning
- To enable nurse assistants to provide preventive measures necessary to reduce negative outcomes of long-term care
- To enable nurse assistants to work well as team members
- To enable nurse assistants to respond appropriately and effectively to emergency situations
- To increase nurse assistants' sensitivity to the psychosocial needs of residents and their families
- To enable nurse assistants to communicate effectively with staff, residents, and residents' families and friends

Course Outline

Unit 1. Orientation

Unit 2. Understanding Residents in Long-term Care

Module 1: Introduction to Long-term Care

Module 2: Understanding Basic Human Needs

Module 3: Sensitivity to Problems of Aging and Disabled Residents

Unit 3. Understanding the Rights of Residents in Long-term Care

Unit 4. The Role of the Nurse Assistant

Module 1: Working as a Nurse Assistant

Module 2: Examining Your Feelings About Aging

Module 3: Developing Communication Skills

Unit 5. Maintaining Infection Control

Module 1: Basic Principles

Module 2: Universal Precautions and Isolation Procedures

Unit 6. Following Safety and Emergency Procedures

Module 1: Promoting Personal Safety–Body Mechanics

Module 2: Promoting Resident Safety

Module 3: Fire and Disaster Preparedness

Module 4: Cardiopulmonary Resuscitation (CPR)

Module 5: Emergency Care and First Aid

Unit 7. Understanding the Aging Process

Module 1: Adjusting Care to Aging Body Systems

Unit 8. Taking and Recording Vital Signs

Module 1: Taking a Temperature

Module 2: Counting a Pulse

Module 3: Counting Respiration

Module 4: Taking Blood Pressure

Unit 9. Admitting, Discharging, and Transferring Residents

Module 1: Admitting Residents

Module 2: Discharging and Transferring Residents

Unit 10. Assisting With Positioning and Moving

Module 1: Positioning the Resident

Module 2: Moving the Resident

Unit 11. Maintaining Residents' Environment

Module 1: Bed Making

Unit 12. Assisting Residents with Personal Care

Module 1: Oral Hygiene

Module 2: Shaving

Module 3: Dressing and Undressing

Module 4: Bathing

Module 5: Perineal Care

Module 6: Hair Care

Module 7: Skin Care

Unit 13. Assisting Residents with Nutrition

Module 1: Daily Dietary Needs

Module 2: Special Dietary Needs and Tray Service

Module 3: Intake, Output and Recording

Module 4: Height and Weight

Unit 14. Assisting Residents with Elimination

Module 1: Daily Elimination

Module 2: Special Urinary Elimination Needs

Module 3: Special Bowel Elimination Needs

Unit 15. Modifying Care for Residents with Special Needs

Module 1: Common Illnesses

Module 2: Physical and Mental Disabilities

Module 3: Caring for the Resident With AIDS

Unit 16. Supporting Residents and Families Through Death and Dying

Module 1: Psychosocial Needs of Residents, Staff, and Family Members

Module 2: Post-mortem Care

Unit 17. Restorative Nursing

Module 1: Optimal Wellness–Self-Care Promotion

Module 2: Exercise

Module 3: Prosthetic and Assistive Devices

Unit 18. Assessment, Care Planning, and Organizing Work Effectively

Unit 19. Closure

Course Development Milestones

• Development contract signed	February 1988
• First Advisory Committee meeting	April 1988
• First draft completed	July 1988
• Review of first draft	July/August 1988
• Second draft completed	December 1988
• Audio-visual production completed for field test	December 1988
• Instructor training for field test instructors	January 1989
• Field test at seven sites	January/February 1989
• Final revisions and audio-visual production completed	July 1989

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The CHAIRMAN. Bruce, your full statement has been included in the record and we do thank you.

We now have Senator Shelby of Alabama.

STATEMENT OF SENATOR RICHARD SHELBY

Senator SHELBY. Mr. Chairman, I thank you.

First of all, I have a written statement I would ask to be included in the record.

The CHAIRMAN. Without objection.

[The prepared statement of Senator Shelby follows:]

RICHARD SHELBY
ALABAMA

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Mr. Chairman, I commend you for holding this hearing today on an issue of such vital concern. On December 22, 1987, President Reagan signed into law the Omnibus Budget Reconciliation Act of 1987, which contained the most sweeping nursing home reform measures since the inception of the Medicare and Medicaid programs. However, our obligation does not stop here.

The 1987 Act requires the Health Care Financing Administration to issue guidelines for implementation and interpretation of the detailed OBRA provisions. We must ensure that the regulations which are promulgated are consistent with the statutory mandate and are issued in a timely manner. I am concerned about the numerous delays and the lack of guidance provided to the states and providers in following the requirements of the 1987 Act.

Mr. Chairman, the purpose of the sweeping reforms was to provide states and providers with greater guidance, and to ensure that residents of nursing homes were receiving the quality of the care that they deserve. Although the provisions of the Act were very specific, guidelines are needed to allow the states the flexibility to administer the new reform measures contained within the legislation. However, this principle has not been accomplished and such guidance has not been forthcoming.

I am anxious to hear from our distinguished witnesses today, and have a number of questions which I would like to ask at the appropriate time. I am especially interested in hearing from the Administration witness, Mr. Anthony, regarding the reasons shy HCFA has decided to implement certain requirements of OBRA ahead of schedule, while other very important deadlines have been delayed.

Thank you Mr. Chairman.

The CHAIRMAN. Senator Shelby, we appreciate your attendance and participation.

Susan, let me ask you a question, if I might. All these things—the "February rule," and whether HCFA has done something prematurely, and the fact that it has missed 10 deadlines—what's the bottom line of all of this? What does all this mean for the nursing home resident out there?

Ms. ROURKE. We really believe that in the home, in the bed, by the bedside, there will be chaos because providers don't know what to do and surveyors don't know how to measure what they don't know what to do.

The mix of the failure to meet the 10 deadlines that you've specified and the fact that the particular set of requirements that are on the floor right now, supposed to be effective in August, don't meet OBRA is a poisonous combination. We think that there can be a return—a real downgrading—to earlier days where people don't know what they're supposed to do and good ideas will be lost. I think it is a very dangerous and chaotic situation.

The CHAIRMAN. All right. Let me ask Toby Edelman. Toby, you're with what group again?

Ms. EDELMAN. National Senior Citizens Law Center.

The CHAIRMAN. Is all of this a back door approach by HCFA to deregulate the nursing homes? I'm trying to understand why this is happening.

Ms. EDELMAN. Senator, I think I'd rather have Susan answer that because I'm presently in court representing Ms. Tulloch's challenge of these regulations. I wouldn't want to characterize it as deregulation.

The CHAIRMAN. I remember in the early 1980's we were trying to deregulate everything. That was the battle cry of the moment and one great institution we ultimately deregulated, now to our shame, was the S&L industry. I'm sure glad we did not likewise deregulate the nursing home industry.

Susan, do you have a comment on that?

Ms. ROURKE. It is clearly poor administration by HCFA. In their actions, they don't know what they're doing. If I were a cynical person, I would say they were intentionally undermining the law. That's if I were a cynical person. [Laughter.]

The CHAIRMAN. At this moment, I'm going to yield to Senator Heinz for any questions that he has.

Senator HEINZ. Mr. Chairman, I was engaged in discussion and I would prefer that you yield to somebody else.

The CHAIRMAN. Could we yield to Senator Cohen?

Senator COHEN. Mr. Chairman, I'm not sure we should try to characterize HCFA's actions at this point until we hear from HCFA itself. As I mentioned in my opening remarks, we have something of an inconsistency here—on the one hand, we have a situation of too late with too much, and too soon with too little. It may be simply a matter of poor administration rather than malicious intent of trying to undermine the efforts of the Congress. So, I think we should wait to hear exactly the explanation before we come to any judgment.

I want to say something to Ms. Tulloch. I regret that the Chairman imposed a 5-minute rule on you. I've had occasion to read, or

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at least read about—I think it was Polly Adler who wrote a book, "A House Is Not A Home." I assume you read that book, too, because you then followed up with your own book, "A Home Is Not A Home." Frankly, looking at your statement, I regret that we could only hear 5 minutes of what you had to say because as an aspiring writer——

The CHAIRMAN. Well, by unanimous consent in the Senate, you can do anything. [Laughter.]

Senator COHEN [continuing]. As an aspiring writer, and I see some aspiring writers over at the table of journalists over there, we could take quite a lesson from the talent that you revealed in your statement. It was really a very poignant statement.

I know you don't want to get into the details, but is the lawsuit premised on the requirements of the Administrative Procedures Act? Is that the basis of the law suit? Toby or Ms. Tulloch may answer.

Ms. EDELMAN. Yes, Senator Cohen, it is. There are several claims, about seven counts, that the regulations are inconsistent with the law, they violate the law, and the regulations that HCFA is planning on implementing through interpretive guidelines is an inappropriate way of implementing the law. We have filed a motion for preliminary injunction, however, on one count, which is the Administrative Procedures Act—that it is not correct to file a final rule with a comment period to follow. That's the basis of the preliminary injunction motion which will be heard next month.

Senator COHEN. Thank you.

That's all I have, Mr. Chairman.

The CHAIRMAN. Senator Kohl.

Senator KOHL. Thank you. I have just one question for Ms. Rourke.

In relation to your closing remarks and the recommendation to delay implementation, this is something that many of the Wisconsin care providers and beneficiaries have indicated they support. Can you tell us if there is any reason at all why we shouldn't delay implementation?

Ms. ROURKE. Not that I'm aware of. We've struggled with this and we think the design that was originally in the act made sense. But since HCFA has not met the original deadlines, those 10 deadlines that have been missed clearly need to be reset, and at the same time this needs to be pushed back sequentially. These requirements were set to be sort of the cap after all these other things were in place, according to the law. And it needs to fit in that way. Putting it in now, dropping it in the middle, is chaotic and I can think of arguments for delaying the implementation at this point. It would give everyone a great breather.

Senator KOHL. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kohl.

Senator Heinz.

Senator HEINZ. I think we're going to have a considerable amount of testimony that says given what HCFA had been trying to do, then OBRA landing on top of it where we imposed some new deadlines—some more rapid, some slower—and where, frankly, we may have made legislatively some mistakes—I'm thinking about

giving OIG civil enforcement authority which really ought to belong to HCFA. How that happened, I'm not sure, but clearly in the light of day, that was wrong. It seems to me that Joe Lieberman is on the right track when he says, "we ought to harmonize those compliance deadlines." It doesn't make much sense to have a compliance required, but enforcement delayed. Nobody I know is saying that enforcement can be moved up without at least violating the Administrative Procedures Act, which no one there at the table is for. So I think you're building a fairly good case for new direction to HCFA.

I would raise one possibility as something that might not be handled totally in sync, and that is whether or not we could urge an accelerated publication on nursing home residents' rights and go to compliance on that notwithstanding the fact that enforcement wouldn't be in place until late 1990. What do any of you think of that? Is that being a little bit pregnant? Should we not do that? It is a little messy but it is something that the States could still probably enforce.

Ms. ROURKE. I'd like to comment and then perhaps Toby could add something too.

Many States already have some of those pieces in place. There will be some difficulty in meshing, but it would be easier to move on those pieces. You're right, it would be difficult. There are also some pieces that we were very disappointed with when we looked at the requirements that they didn't move on as quickly as possible.

Toby, you can answer the specifics.

Ms. EDELMAN. The specifics about residents' rights, I think that's something we should explore. There may be some additional provisions that need to be in those residents' rights that could go forward as final regulations.

Residents' rights have been talked about as being elevated in importance since 1986, when it was proposed by the Department. There has been a lot of effort and interest in that and I think that's certainly something that should be explored about having the residents' rights be published as final now.

Senator HEINZ. Ms. Tulloch, any comment?

Ms. TULLOCH. I find residents' rights very difficult. You can talk about them here but I can never feel them by myself in my room. I'm here to tell you, you can't tell housekeeping that I'm entitled to my privacy.

Senator HEINZ. I understand your point. How do you get the rights and how do you guarantee those rights? It is very, very difficult. A number of us have been working on this issue since before 1982 and here we are 7 years later and we don't have anything implemented. Even if we did, you raise the question of how can it really work.

Ms. TULLOCH. They can't be guaranteed. You cannot expect housekeeping personnel to recognize residents' rights if HCFA writes those kinds of requirements.

Senator HEINZ. Thank you. It's a good point.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Heinz.

Are there any further questions from the committee? I think we're going to leave the record open for a few days on written questions to be submitted to our panel, if you would be so kind as to answer those questions to the best of your ability.

At this point in the record, I'm going to place a three-page summary that our Aging Committee staff has developed. These are the 10 obligations imposed upon HCFA to comply with OBRA 1987. They also are the 10 deadlines that have been missed. I'm going to place that in one part of the record.

The next summary that has been prepared that I will place in the record are the States' obligations under OBRA. The third page will be the facilities' obligations. I think it would summarize the three facets of what we're talking about this morning. I will place those in the record because I think it will be of future use.

[The information follows:]

NURSING HOME REFORM IMPLEMENTATION DATES
(Deadlines for Facilities, States and HHS)

The MCCA of 1988 includes technical amendments to the OBRA 1987 that conform a number of nursing home reform implementation dates that were different for Medicare and Medicaid facilities. Where different Medicare and Medicaid requirements or implementation dates still exist, they are indicated in parenthesis.

DHHS Obligations

1988

Jan. 1 — HHS: Enforce alternative sanctions (Medicare) **DEADLINE MISSED**

Mar. 1 — HHS: Publish standards for nursing facility administrators (Medicaid) **DEADLINE MISSED**

July 1 — HHS: Specify nursing home costs which may be charged to residents' personal funds and those which are covered by Medicare or Medicaid, as applicable **DEADLINE MISSED**

Sept. 1 — HHS: Establish requirements for nurses' aide training and evaluation **DEADLINE MISSED**

Oct. 1 — HHS: Set minimum guidelines for appeals procedures for residents who are transferred or discharged **DEADLINE MISSED**

HHS: Develop criteria for preadmission screening of mentally ill and retarded residents and appeals procedures for residents adversely affected by screening **DEADLINE MISSED**

HHS: Develop criteria to monitor state waivers of licensed nursing requirements **DEADLINE MISSED**

HHS: Provide regulations on alternative sanctions **DEADLINE MISSED**

1989

Jan. 1 — HHS: Specify a minimum data set of core elements and common definitions for resident assessments and guidelines for their use **DEADLINE MISSED**

Mar. 1 — HHS: Develop minimum qualifications for SNF administrators (Medicare) **DEADLINE MISSED**

1990

Jan. 1 — HHS: Develop and validate protocol for standard and extended surveys

Apr. 1 — HHS: Designate resident assessment instrument(s)

States' Obligations

1988

Apr. 1 — STATES: Develop a notice of residents Medicaid rights

1989

Jan. 1 — STATES: Approve nurses' aide training and competency evaluation programs that meet state requirements

STATES: Establish a registry of aides who have satisfactorily completed training and evaluation

STATES: Begin preadmission screening of new applicants to nursing homes who are mentally ill or retarded; establish appeals process for those adversely affected by screening (Medicaid)

Apr. 1 — STATES: May develop alternative agreement with HHS for handling of mentally ill and retarded residents (Medicaid)

July 1 — STATES: Implement standards for nursing facility administrators (Medicaid)

Oct. 1 — STATES: Provide appeals procedures for residents involuntarily transferred and discharged

STATES: Establish alternative sanctions

1990

Jan. 1 — STATES: Implement SNF administrator standards (Medicare)

STATES: Begin review and reapproval of aide training programs

Apr. 1 — STATES: Begin annual review of current residents who are mentally ill or retarded to determine whether they are appropriately placed and need active treatment (Medicaid)

STATES: Submit amended Medicaid plan to HHS showing payment adjustments to comply with new requirements

July 1 — STATES: Specify a resident assessment instrument

Oct. 1 — STATES: Survey and certification requirements become effective

Facilities' Obligations

1988

July 1 — FACILITIES: Provide state ombudsmen, physicians and federal and state representatives immediate access to residents

1989

Jan. 1 — FACILITIES: May not admit new residents who are mentally ill or retarded and who do not need the level of care provided in the facility (Medicaid)

July 1 — FACILITIES: Begin competency evaluation of currently employed aides

Oct. 1 — FACILITIES: Begin notifying residents of their transfer and discharge rights (Medicaid)

1990

Jan. 1 — FACILITIES: Complete competency evaluation of currently employed aides

FACILITIES: Implement training and competency evaluation for all newly employed nurses' aides

Oct. 1 — FACILITIES: Provide 24-hour licensed professional nursing services and a full-time RN seven days a week, unless waivered

FACILITIES: Begin conducting comprehensive assessments at least annually of residents admitted after this date

FACILITIES: Begin notifying residents of their transfer and discharge rights (Medicare)

NOTE: All requirements not otherwise specified become effective on this date, including elimination of the distinction between skilled and intermediate care facilities

1991

Jan. 1 — FACILITIES: Complete assessments of all residents admitted prior to October 1, 1990 (Medicare)

Oct. 1 — FACILITIES: Complete assessments of all residents admitted prior to October 1, 1990 (Medicaid)

The CHAIRMAN. I want to thank this panel this morning. You've been very helpful, and constructive.

Thank you very much.

I'm going to call our second panel.

STATEMENT OF SENATOR JOHN WARNER

Senator WARNER. Mr. Chairman, if I could ask for unanimous consent——

The CHAIRMAN. Oh, Senator Warner, I want to apologize to you——

Senator WARNER. No, no, no. I'm fine. I just ask that a statement that I prepared be submitted for the record.

The CHAIRMAN. I was not aware that you were here. I do apologize. This is my blind side.

Senator WARNER. No, no. I move very quietly, Mr. Chairman. You've always accorded me every opportunity to participate and I thank the Chair. I commend the Chair for holding these hearings.

[The prepared statement of Senator Warner follows:]

JOHN W. WARNER

May 18, 1989

Hearing Before the Special Committee on Aging

"HCFA Implementation of OBRA Nursing Home Reforms"

MR. CHAIRMAN, SENATOR HEINZ, I AM PLEASED THAT THE COMMITTEE IS TAKING THIS TIMELY ACTION TO EXAMINE THE IMPLEMENTATION BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) OF THE LANDMARK NURSING HOME REFORM PROVISIONS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA).

THE OBRA PROVISIONS REPRESENTED THE CULMINATION OF TWO DECADES OF REVISION AND REVIEW, BASED ON THE FINDINGS OF THE MAJOR 1986 REPORT OF THE INSTITUTE OF MEDICINE (IoM), "IMPROVING THE QUALITY OF CARE IN NURSING HOMES." THE COMMITTEE HAS FOUND THAT HCFA HAS REPEATEDLY FAILED TO MEET FUNDAMENTAL TIMELINES FOR PROGRAM IMPLEMENTATION, WHILE ISSUING FINAL RULES FOR MAJOR PORTIONS OF THE BILL WITHOUT ADEQUATE GUIDANCE FOR THE STATES AND NURSING HOME ADMINISTRATORS.

OF PARTICULAR CONCERN TO ME HAS BEEN THE IMPLEMENTATION OF THE OBRA PRE-ADMISSION NURSING HOME STANDARD, REQUIRED AS OF JANUARY 1, 1989, WITHOUT THE BENEFIT OF FINAL FEDERAL REGULATION. WHILE NURSING HOMES HAVE BEEN ATTEMPTING TO COMPLY WITH OBRA, IT IS MY UNDERSTANDING THAT ADMISSION STANDARDS AND PROCEDURES FOR MENTALLY ILL AND MENTALLY RETARDED PATIENTS MAY BE RESULTING IN DENIED PLACEMENTS WITHOUT REFERRALS TO APPROPRIATE SETTINGS.

ONE OF THE PRINCIPAL PURPOSES OF OBRA WAS TO PROVIDE A "BILL OF RIGHTS", IF YOU WILL, FOR NURSING HOME RESIDENTS - - - TO FINALLY PROVIDE UNIFORM STANDARDS OF CARE AND SERVICES. NURSING HOME RESIDENT ADVOCACY GROUPS HAVE BEEN ELATED OVER THE LEGISLATION, AND IT IS ENCUMBENT UPON US TO SEE THAT THE NEW STANDARDS ARE EFFECTIVELY IMPLEMENTED.

MR. CHAIRMAN, I WELCOME THIS OPPORTUNITY TO HEAR FROM CONCERNED WITNESSES, NURSING HOME PROVIDERS, AND THE RESPONSE OF THE HEALTH CARE FINANCING ADMINISTRATION. I AM READY TO LEND MY SUPPORT TO WHATEVER EFFORT IT TAKES TO ASSIST HCFA IN MAKING THESE HISTORIC NURSING HOME REFORMS A REALITY.

QUALITY OF LIFE SHOULD NOT BE CHECKED AT THE DOOR OF A NURSING HOME. I WANT TO BELIEVE THAT THE VAST MAJORITY OF NURSING HOMES ARE INDEED PROVIDING APPROPRIATE LIVING ENVIRONMENTS FOR THEIR RESIDENTS.

LET US NOT COMPLICATE THE SITUATION BY SENDING CONFUSING GUIDANCE FROM WASHINGTON. GIVE NURSING HOME PROVIDERS THE TOOLS THEY NEED TO PROPERLY MAINTAIN THEIR FACILITIES, AND AT THE SAME TIME, LET US BE SURE THAT NURSING HOME RESIDENTS AND THEIR FAMILIES WILL HAVE A CLEAR SET OF STANDARDS, DEFINING WHAT THEY MAY REASONABLY EXPECT IN TERMS OF CONDITIONS OF CARE AND SERVICES.

The CHAIRMAN. Thank you, Senator Warner.

We have three witnesses on the second panel: Dana Petrowsky, the representative of the Association of Health Facility Licensure and Certification Directors, and the Administrator of the Division of Health Facilities, Iowa Department of Health; Kenny Whitlock, Deputy Director, Division of Economic and Medical Services, Arkansas Department of Human Services; and then Linda Rhodes, Secretary of the Pennsylvania Department of Aging.

We have a request which will be honored. Linda has a plane to catch in a very short period of time and has to get back to Pennsylvania, so we're going to reverse our order and call on Linda Rhodes.

Senator HEINZ. Mr. Chairman, could I prevail on your good will just to say a few words.

The CHAIRMAN. I thought you were going to do something like that. [Laughter.]

Senator HEINZ. First, Mr. Chairman, let me thank you for putting Linda on first. She has to report to our Chief Executive in Pennsylvania, Governor Casey, by 1 o'clock this afternoon. She does bring very specific qualifications to this hearing today. Not only is she a gerontologist, but she also holds, as the Secretary of the Department of Aging in Pennsylvania, very specific responsibilities for implementing the kinds of programs we're discussing here today. Indeed, because of her leadership, I think it is fair to say that our State has been able to move ahead with many innovative aging programs—prescreening, case management, quality assurance—all of which have put our State in a somewhat better position than many other States to implement the OBRA 1987 quality reforms. So I would expect that she will tell us that in spite of Pennsylvania's relatively good positioning, even Pennsylvania has not enough expertise and enough time to meet HCFA's accelerated time frames.

Mr. Chairman, you put into the record a few moments ago the deadlines HCFA's missed; maybe that's a blessing in disguise.

The CHAIRMAN. Linda, we're very pleased to have you testify before the committee today.

STATEMENT OF LINDA RHODES, SECRETARY, PENNSYLVANIA DEPARTMENT OF AGING

Dr. RHODES. Thank you very much and good morning.

As Secretary of the Department of Aging, I thought it would be helpful to spend one moment talking about the Department. It was created 10 years ago because older people across the State felt it was very important to have a Department that would be a Cabinet level position. We now have 2.5 million people over the age of 60 in the State and the whole focus of the Department of Aging is to be a strong advocate. We are not a regulator, we do not license anything, but we're to be seen as an advocate within State government, within the administration, and for older people in general.

In the interest of time I'm going to highlight several issues that are addressed in more depth, of course, in our written testimony. I want to focus on things that concern me as our State scrambles to meet the deadlines imposed upon us.

As Senator Heinz has stated, we do think Pennsylvania is in better shape but we are also scrambling to meet this challenge. The reason we feel we're in better shape is that we have been conducting preadmission assessments for the past 4 years for many of our individuals who are needing nursing home care throughout Pennsylvania. Because of that, we were able to implement HCFA's regulations and requirements on prescreening within 120 days of the mandate. Most of the new licensing requirements for providers we had in operation a year ago with our own State law. But like all other States, we do have very deep concerns and to be perfectly honest with you, we are scrambling as well.

I'm worried that in the rush to implement landmark legislation, we may harm the very people we are trying to help. Three issues stand out.

The first, and perhaps most difficult, is the issue of evaluating the competency of a nurse aide. I think no one disputes the wisdom of educating nurse aides. We all support this. What immediately confronts us is how we test them. In order to offer a test so quickly, large commercial testing businesses seem the fastest and most economical way to meet HCFA's mandate. But we are relegating ourselves—in research terms—to "quick and dirty" methods of validating tests. Quite frankly, we aren't sure how to test for what the law has asked and for what we feel is very important—how to test for the things that we're most concerned about, skills in communication, the values of caring and the empathy that we expect nurse aides to be able to have.

We have 42,000 nurse aides in Pennsylvania that must be tested within the next 6 months. In order to test these mass numbers we have short circuited the process of designing an instrument we can believe in. Instead we have placed the nurse aides' testing skill on trial rather than placing the test on trial. It will take time and a good research design to validate the test. Once we launch this evaluation effort, there is no going back with the test and all the paraphernalia that goes with it.

Our second worry stems from the confusion over screening and admissions policies, especially in regard to mental health. Providers now are faced with a dilemma—either they admit a patient with assessed needs for treatment, for which they are not reimbursed, even though the patient's primary need is for nursing home care; or they refuse to admit the patient because they cannot meet all of the patient's needs, as the law says they must. We really can't let that happen. It is also only fair to make sure that the regulations and the reimbursement policies are integrated and fit together. As States, we, too, have legislatures, budget secretaries, administrations to contend with and it's not so simple to add these in.

My final point speaks to the new survey and certification requirements that our Secretary of Health asked me to mention to you today. As you know, these requirements are going to focus on quality of care more than standards. We strongly believe in that. However, it is going to require at least 40 percent more time of these individuals. What we're most concerned about, again, is that they need to be trained and educated in doing this, and the training materials so far are really insufficient.

Finally, Senators, it calls for a time when the States and Federal Government sit down at the same planning table together, ask each other what we need to do in order to do this job, and to go about the business of doing it right.

[The prepared statement of Dr. Rhodes follows:]

TESTIMONY
U. S. SENATE SPECIAL COMMITTEE ON AGING

Implementation of OBRA '87

Dr. Linda M. Rhodes
Secretary of Aging
Commonwealth of Pennsylvania

Department of Aging
Commonwealth of Pennsylvania
May 18, 1989

My name is Linda Rhodes, and I am pleased to have been asked to offer you my thoughts on this most important subject for Older Americans.

As Secretary of the Department of Aging for the State of Pennsylvania, I have the responsibility of overseeing a budget of $320 million for direct services to older people, half through Area Agencies on Aging and half through the PACE program. As one of the top four graying states in the country, we spend over $1.2 billion on services for 1.5 million older Pennsylvanians.

Our state has been a leader in the development of community-based care for the elderly for years. Less well-known, but equally true, is that Pennsylvania has been among leaders in state policy in all branches of the long term care field. The new nursing home licensure standards imposed by OBRA were almost entirely anticipated by state law the year before. The pre-admission screening and annual resident review requirements fit neatly and logically on to our Long Term Care Assessment and Management Program demonstration (LAMP), enabling the Department of Aging to develop statewide assessment capacity through our area agencies on aging in the span of about four months. It was a crash program to be sure, but we got it done.

Despite our relative preparedness, however, I am here to say that we in Pennsylvania cannot sort out all the confusion, read the conflicting signals and also meet these deadlines. And if we can't do it in Pennsylvania, then I believe it is a problem in most other states as well.

Because of the geriatric mandate demanded by these demographic trends in Pennsylvania, the Governor has charged me with two additional responsibilities. The first is to chair the Intra-Governmental Council on Long Term Care whose mission is to develop a state policy on long term care within the next six months. The appointees represent providers, the legislature, consumers and cabinet members.

The second charge is for me to chair the cabinet level Nursing Home Reform Team (NHRT). The sole purpose of the NHRT is to coordinate OBRA developments among the Departments of Welfare, Health, Education, the Governor's Office and the Secretary of the Budget. It is in this role that I appear before the committee.

Pennsylvania endorses the principles embraced in the Nursing Home Reform Act. As advocates for nursing home residents and managers of the public trust, we believe that this law represents an important development in the field. But, we as a state and we as a nation are at risk of doing the public harm in the name of doing good. In the rush of fixing a major social problem -- care of our older people in nursing homes -- we are running helter skelter towards solutions that we know little about.

The purpose of this hearing is to advise you on the impact of the implementation of nursing home reform provisions included in OBRA '87 as experienced by the states. Let me say in fairness to HCFA that they have been asked to accomplish a monumental task. I am not here to complain about a federal agency. I come here in the spirit of cooperation -- to ask that Congress and HCFA consider calling for a brief time-out that will enable all of us to re-examine how we can get to where you want to lead us.

An Ethical Dilemma

The requirement that nursing homes be expected to meet all the needs of patients presents a dilemma for providers, patients, and states alike. On the one hand, our assessment procedure will tell us a great deal about what a person's needs are for care of all types. On the other hand, nursing homes are not reimbursed for certain kinds of care, mental health services being the most obvious and pressing. We believe there will be many patients who, as a practical matter, due to needs for health and personal care and supervision, appropriately need to go into nursing homes and who have mental health problems that fall below the threshold of active treatment. As it stands, providers have to risk that they will be found at fault for not meeting identified needs even though they are not paid to provide many services. In the alternative, they must refuse the patient, resulting in the patient not even getting their health care needs met appropriately, and all in the name of providing appropriate services. The patient is harmed in this equation, and we cannot allow that to happen.

Since OBRA '87 contained no patient services reimbursement initiatives that we know of, we assume that it was not the intent of Congress to dramatically widen the role of nursing homes as providers. Rather, it was the intent of Congress to improve the general practice in nursing homes and to assure that they don't become warehouses for people that states do not want to care for appropriately. We agree with that purpose, and ask that when regulations are finalized, three conditions are met:

1) States are given reasonable time to implement the regulations before the date of enforcement. This must include time for state legislatures to review budgetary effects and authorize changes.

2) Responsibilities of providers are clearly spelled out regarding the kinds of care they must do.

3) The responsibilities of providers for nursing home patients be directly correlated with Title XVIII and Title XIX payment policy.

Nurse Aide Training and Competency Evaluation

Those of you who voted for this legislation endorsed the premise that a nurse aide who received a good education would provide better care.

I, like many other educators, advocates, practitioners and nurse aides themselves, agree with you. But the law goes further in that it requires that we as a state must evaluate what the nurse aide knows. It is this "knowing what they know" (some people call this testing) that brings us to the point of making some tough public policy choices at the state level.

Let me share with you an example of what we in the Pennsylvania Cabinet are currently wrestling with in regard to testing:

We estimate that there are 42,000 nurse aides in the state of Pennsylvania. Some of them may be deemed competent and not obliged to take the test, but most of them will have to. We estimate that we need to offer at the very least 50,000 tests within the last six months of 1989. We received the latest DRAFT issuance on testing from HCFA several weeks ago. They still aren't the real thing. The law -- not regulations -- require that all nurse aides are to be tested by January 1, 1990. Nursing homes cannot retain currently employed aides who have not passed the test. Long term care in nursing homes is jeopardized. Perhaps thousands of nursing aides lose jobs they want and do well, and patients lose the care they need. None of us wants to see that happen. And if it does happen, it will be because of the tests.

A number of us in the cabinet have professional concerns on how we are going about testing people:

- In order to develop and offer a test so quickly, large commercial testing businesses seem the fastest and most economical way to meet your mandate. But a number of researchers and educators contend that we are relegating ourselves to "quick and dirty" methods of validating tests. Rather than take the time to adequately answer the question, "Is this test a valid reflection of the kind of knowledge, skills and values a caring and competent nurse aide should offer?", we have short circuited the process and placed the nurse aide on trial rather than the tests.

- We know people will fail this test in great numbers. Some states predict that as many as 50 percent of the aides will fail the test. Our answer? Create study manuals and mini-tests to help them pass the test. I would counter that if that many people are failing the test, it is the test that has failed, not those who have taken it. The TEST has now taken center stage and we've lost sight of what brought us here in the first place - teaching, learning, coaching, and caring.

- Look at who we are testing. They are women who have worked at home for years caring for children and other relatives, often displaced homemakers. Many have limited reading skills, but powerful caring instincts that cannot be measured with a pencil and a piece of paper. Still others are older workers who have not had to take a test in years. We are already hearing about the beginning of an exodus out of nurse aide positions to other roles in nursing homes and out of the industry altogether. For an industry that is already finding tremendous difficulties filling positions, these problems pose monumental concerns.

We simply need more time to get this right and avoid an unnecessary and tragic disaster. Once this test and all the paraphernalia that goes with it is launched by the states, there's no going back. In Pennsylvania, we want to conduct an added research effort with regard to testing that I believe will make this a much better, more valid evaluation. But you have to take the gun away from our head. Nursing homes are fearful that even if the state takes the risk and improves the test, they at a later date will find HCFA auditors looming in their doorways, ready to fine them. We ask the implementation date for nurse aide certification be moved back from January 1, 1990 to July 1, 1990 and that certification requirements for aides employed by home health agencies be moved back correspondingly.

Survey and Certification

In the area of survey and certification, we have been advised that HCFA will hopefully be training our surveyors on July 1 through manuals and video tapes for implementation on August 1. The review protocol stipulated for use is untested, and the terms involved in the new survey, such as "highest practicable level" need to be clarified. We in Pennsylvania are currently involved in a major expansion of our surveyor workforce to clear up backlog problems that date back to 1980. HCFA's own estimates are that the new requirements will expand the typical survey visit from 64 to 106 person-hours, a 40% increase. For all these reasons, we cannot meet the August 1 deadline. We believe a target date of February 1 or March 1 of 1990 would allow us to have personnel who have been fully trained, and would allow HCFA to more fully develop their training and surveying technology.

The following is a list of specific suggestions and requests for clarification that have been collected from other agencies in Pennsylvania state government.

- Issue timely regulations which will permit all parties to meet the requirements of the Act. Programmatic and fiscal decisions are being forced on states without benefit of clear regulations.

- Assist the states in describing how the annual resident review of mentally disabled residents can be integrated into the nursing home reviews of residents in order to reduce duplication of effort.

- Hold states harmless for decisions they make regarding the categorical exclusion from PASARR of certain mental disorders in AXIS II.

- HCFA (or another Federal Agency) should establish a clearinghouse or coordinating unit for dissemination of ideas/concepts from one state to another so that each state's efforts to operationalize pre-admissions and residential evaluations are made available for all to utilize.

- Because few staff from evaluation agencies or program offices understand ramification of NF applicants having to take prescribed drugs (and responses to those drugs), we strongly recommend deletion of the PASARR/MR screening criteria dealing with "current responses of individual (applicant) to any prescribed medications in the following drug groups: hypnotics; anti-psychotics (neuroleptics); et al." from the State Medicaid Manual (May 1989 transmittal).

- Relieve state authorities of the responsibility for determining which nursing facility or facilities are appropriate for an individual's needs.

In summary, our request to you is that you provide us with clearer policy guidance, clear program regulations, clear information on payment policy and reasonable time periods to implement policies before sanctions are enforced. With these and the suggestions provided herein, the State of Pennsylvania will gladly join the Federal Government in implementing this most important legislation.

The CHAIRMAN. Thank you very much for your statement. I'm going to allow members of the committee to ask any questions of you now because I know you have to catch a plane.

Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you very much.

Dr. Rhodes, Linda, thank you for a very fine short summary of the problems that Pennsylvania has encountered. I commend you on the fine work that you do up there on a daily basis keeping our State moving ahead.

On the preadmission screening that you mentioned, and where HCFA was supposed to have implemented regulations by October 1, 1988, if I'm not mistaken, for mentally ill and retarded patients, would it not be the case that if this were rushed ahead without States making appropriate arrangements for people who were screened out, you might end up with a very discriminatory and problematic situation?

Dr. RHODES. Exactly. One of the things that we've done because of OBRA is that we created a Nursing Home Reform Team of the Cabinet, consisting of the Secretary of Education, to do the nurse aide testing; the Secretary of Welfare—because they do many of the regulatory pieces to this; the Secretary of Health, and then myself. They asked me to chair it because the Department of Aging doesn't regulate anything. This is also coordinated with the Governor's Office.

One of the dilemmas that we're all dealing with right now is that, in the counties in which we have been demonstrating preadmission assessment, we always had the services to go with it. We thought this was very important. The Department of Aging can go to a family member by doing this assessment and can say to them, you don't need to go into the nursing home, instead we can offer you a whole set of services—adult day care, someone coming in offering personal care, and so forth—so that your family member can stay in the home. We've been able to provide those services so that they can make this choice.

This is one of the problems that you've identified, Senator Heinz, because the reimbursements for services aren't going with the assessments. We're sitting down at budget tables, taking a look at budgets we've already drafted. One of the ethical dilemmas of assessing people, essentially telling them what they need or don't need, is the instance when you know they could be better provided for in the community yet the alternate services that could make this possible don't exist. You've pinpointed a dilemma that we're dealing with at the State level.

Senator HEINZ. If Congress should decide to change the final effective date of those regulations to October 1990, is that enough time?

Dr. RHODES. I think it would be. It especially would help us in terms of our budget cycle. It would allow us the opportunity to sit down and work with the legislature since we're on a different fiscal cycle than you are.

Senator HEINZ. On the requirement for nurses aide training evaluation, I think it was fascinating hearing you describe how difficult it is to make sure that is done and done well and done right. What should we do there? Should we move that September 1 deadline

one way or another? Should we move it as far as October 1990, or not?

Dr. RHODES. We absolutely need more time. One of the things that we're doing right now within the Cabinet—in fact, we're meeting tonight on it—is debating about the consequences of having our tests ready in 3 months. One of the things we want to do is conduct a separate study where we could analyze the kinds of performance behaviors that we hope our evaluation will be able to identify. We want to make sure that the evaluation instrument actually tell us something about how people perform.

We need to take a look at what is considered good behavior of a nurse aide. We plan to develop a study of discriminate validity in which observers would rate people in their natural work setting, and then have them take the test and see if there is a relationship. If there is a high correlation between good job performance and test performance then we think we have something there. We're having very heated debates among ourselves on other topics as well. Some of us feel very strongly that we should have oral tests. As I tour the State, I hear very much from nurse aides and nursing homes administrators who are saying that they would like to have an oral test. We have many older workers, older women who are very frightened when hearing that our Department of Education is now looking at a 92-item written examination. On the other hand an oral test is sometimes difficult to give while there are reliability problems, and cost issues associated with it, too.

So we're debating these kinds of issues and we need more time because I think we really have to consider what we're doing once we launch this. I'm concerned about losing very good, caring, competent nurse aides out there whom we desperately need, because now this test is completely driving the system.

Senator HEINZ. Linda, Dr. Rhodes, thank you very much.

Mr. Chairman, thank you for allowing me to question Dr. Rhodes.

The CHAIRMAN. Thank you, Senator Heinz.

Senator Cohen.

Senator COHEN. I have just one point. We have somewhat of a similar problem in the State of Maine, which has a very good long-term care program. We actually exceed the Federal regulations as far as nurse aide training is concerned—150 hours are required in the State. There is some confusion apparently because the guidance letter that has been issued by HCFA would indicate that testing is not required whereas the regulations themselves indicated that it is. So they are in somewhat of a turmoil in the State of Maine as to what to do, to go forward with the testing or face the penalties if they don't go forward. So, that's another area of confusion between guidance letters and the regulations themselves.

We also have another situation with the preadmission screening where, if a mental illness is found, the individuals must be sent to psychiatric hospitals and, of course, we don't have a place to put such people in the State of Maine. That's something that we hope we can address here during the course of the hearings.

Dr. RHODES. In Pennsylvania the Governor recently created a Long-Term Care Council to address much of the confusion in long-term care that you just cited. We have on that council consumers

and providers, people in the industry, people who have even sued the State as advocates have chaired one of our committees. I think it's so important that we have this kind of partnership. And it's the same with the States and the Federal Government—I think we can both learn from each other. The States are dealing with the operational issues and we really need to sit down with the Feds at the same table and share our experience to make this thing happen.

Senator COHEN. Can you comment as far as what the attitude of some of the nurses might be? We are told that nurses are intimidated by the appeals process. If they are accused, for example, of having mistreated a patient, that accusation goes in the record, they stand in essence convicted of the accusation unless they follow the appeals process; they're intimidated by that, and this is causing a problem as far as availability of nurses. Do you have any comments on that?

Dr. RHODES. I haven't really talked to them that much on this issue. I do know, though, from working with nurses, that there is a fear with the whole appeals process in general and a punitive aspect to it. The whole idea of OBRA was to coach and educate people to improve quality of care. Instead its taken such a punitive mode and I think we really have to get past this.

Senator COHEN. Thank you very much.

The CHAIRMAN. Thank you, Senator Cohen. Senator Shelby.

Senator SHELBY. Thank you, Mr. Chairman.

If you could reduce it to a couple of areas and focus in, and it would be hard, what are the two biggest failures as far as you're concerned of HCFA in this area?

Dr. RHODES. Well, the major one that I've been most concerned with is on the nurse aide testing. It seems to me from when you read the regulations——

Senator SHELBY. Covers a lot of ground, doesn't it?

Dr. RHODES. It does. I think part of it is just not understanding what the operational impact was going to be or how you make it happen. The only way you know that is by sitting down with some key States. Some of us have had good experience in what we've been doing and we need to share that. I don't know how else you'd find out from them unless you sit down and work with them, especially those who are operating it. That seems to me what's so disjointed, there is not an operational understanding of how to get there.

Senator SHELBY. Do you think HCFA understands how they are going to get there?

Dr. RHODES. Maybe you can help them.

Senator SHELBY. We hope to help them.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Shelby.

Senator Warner.

Senator WARNER. Thank you, Mr. Chairman.

We welcome the participation by this witness, who clearly manifests by her testimony that she's well qualified to contribute to this debate.

I've never been one to believe that all the wise old owls in the world are here in Washington, DC, and I think this problem is testimony to that.

What did your State do prior to the Federal intervention in this area?

Dr. RHODES. We had pretty strong action by developing a Long-Term Care Council. I think we've had a strong legislative history in dealing with aging because we've had to, since the numbers of older people are growing so rapidly. Our other area of strength is an extensive ombudsman program.

I think having a Department of Aging at the Cabinet level has been very helpful since there is such a strong constituency that we've had to answer and work with. With regard to preadmission assessment, we've been doing this for almost 5 years, and had set ourselves in a position to expand statewide. We were actually happy about OBRA because it provided an impetus to make us move faster. We've been wanting to go statewide for quite a long time.

Senator WARNER. What standards did you use in the past for your nurses aides?

Dr. RHODES. One of the issues with Pennsylvania is that we didn't have any statutory base for that. We were looking to develop this. A number of States—New York, California, others, have some very good laws on the books of what a nurse aide ought to know and we were going to start moving in that direction. But we didn't yet have that, so when OBRA came about, we felt we didn't need the legislation and we moved on. We have not been that strong in this area.

Senator WARNER. Are there some aspects of the HCFA that are positive in your judgment?

Dr. RHODES. I think what's positive is that the regulations and what they're trying to do does make sense. That's not what's awry here. I think part of it is this frenzied environment that's been created on meeting these deadlines without thinking, or doing any critical path planning of what is going to affect all the other pieces. We really must go back and do that.

Senator WARNER. So given some flexibility in the timing, you think we're moving generally in the right direction?

Dr. RHODES. Yes.

Senator WARNER. Learning from our experience—the positive aspects, the negative aspects—and that generally the health care provided will be better?

Dr. RHODES. We're on the right track but we need some time to do it correctly.

Senator WARNER. I think that's a very clear message. Thank you.

The CHAIRMAN. Senator Warner, thank you.

Any further questions for Dr. Rhodes?

Let me ask one final question. Your State seems not only advanced in relation to many of the other States in this field, especially in screening. Can your State comply with the February rule, which means that August 1 you are going to start complying with these new rules? Can Pennsylvania comply with this?

Dr. RHODES. We're having real problems complying. The Secretary of Health, I know, has gone to the Governor, especially in regard to the survey requirements. We don't feel that we're going to be able to meet that August 1 deadline.

The CHAIRMAN. Thank you very much, Linda.

Dr. RHODES. Thank you very much for allowing me this flexibility in presenting testimony.

The CHAIRMAN. Thank you very much. We appreciate your contribution.

Senator HEINZ. Mr. Chairman, if I may, I'd just like to join in thanking Linda Rhodes.

Linda, I hope you make it.

Dr. RHODES. I hope so, too.

Senator HEINZ. We don't want you to get fired. If there's any trouble, blame it on me.

Mr. Chairman, may I impose for 15 or 20 seconds?

The CHAIRMAN. Certainly.

Senator HEINZ. I have to go up to that Securities Subcommittee hearing but I just want to commend you on these hearings. We got into the nursing home reform question back in 1982 when the then-Reagan Administration proposed to loosen nursing home regulations. We brought in the Institute of Medicine, we brought in a number of experts, we held hearings literally over the next 4 years, we made some modest improvements in 1986, OBRA 1987, and we've really come not only full circle but a very long way.

First, we've changed the direction that the Government was going quite clearly and forcefully. And second, we have really developed a very careful, I think reasonably comprehensive—even if it doesn't go as far in some areas as I might have liked—approach to improving the quality of care in nursing homes. I don't think any of us should be under any illusions that that's not an easy thing to do. If it were easy, we would have done it when you were a Member of the House of Representatives and did so much in that regard yourself.

So, it is my view that it's important to take not more time than we need, but the amount of time it takes to do it right because if we mess up, if we proceed and impose on HCFA deadlines that for either good or bad reasons they can't meet, and we impose helter-skelter on the States requirements that are unclear, as Linda Rhodes has testified to, or that they take guidance from letters that are inconsistent with regulations which are inconsistent with laws, or where laws are inconsistent with our intent—as in the case of having OIG do things that HCFA should be doing—we don't do the nursing home residents any favor because we sow confusion among the providers, the regulators, and ourselves. We set the stage for retreat. As somebody who, together with you, Mr. Chairman, has worked very hard to get this far, the last thing I want to see us do is retreat. What I think we need to do is advance in order.

Thank you, Mr. Chairman. I appreciate your allowing me this time to offer my comments and observations.

The CHAIRMAN. Thank you, Senator Heinz.

Dana.

STATEMENT OF DANA PETROWSKY, REPRESENTATIVE OF ASSOCIATION OF HEALTH FACILITY LICENSURE AND CERTIFICATION DIRECTORS, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS, AND ADMINISTRATOR, DIVISION OF HEALTH FACILITIES, IOWA DEPARTMENT OF INSPECTIONS AND APPEALS

Ms. PETROWSKY. Mr. Chairman and members of the committee, I'm Dana Petrowsky and I'm the Administrator of the Division of Health Facilities in the Iowa Department of Inspections and Appeals. I'm proud to be representing the State of Iowa, the Association of Health Facility Licensure and Certification Directors, and the Association of State and Territorial Health Officials for the United States.

I've been certifying nursing homes for Medicare and Medicaid since 1975, 14 years. There can be no doubt that these Federal programs have contributed substantially to the improvement of care as well as the expansion of services in the United States.

I was also a member of the Committee on Nursing Home Regulation at the Institute of Medicine, National Academy of Sciences. We authored the report, "Improving the Quality of Care in Nursing Homes," which was the basis of OBRA 1987 nursing home reform.

I want to acknowledge Congress and members of this committee, such as yourselves, who have allowed this report to be enacted almost totally within the following year after its issuance. The awesome promise of nursing home reform is now before us and we are now challenged to develop a system and framework for its implementation. The importance of the work now being done cannot be overstated.

Let me make it very clear here today that the States stand firmly behind the goals of nursing home reform. We are ready to hold up our side of the Federal-State partnership in assuring high quality health care. We would like to here today acknowledge the staff of HCFA for their openness and for using a process which promotes participation by the States. The commitment we have seen on the part of numerous staff in HCFA to developing a viable system of quality assurance, their many hours of work are to be applauded and we do so here today.

Of great concern to the States is the slated implementation of the new requirements for nursing homes by August 1. This is ill-advised and premature. It is going to further chaos in a system already under stress. Implementation of the new requirements and survey procedure should be pushed back to October 1990, as is required by the Act.

The linchpin of the new survey process is mandatory, uniform resident assessment. This will not be ready until October 1990.

In the February 2, 1989, Notice of Final Rule Making Regulatory Impact Statement "Effect on the States," it is said that these new standards will not cost the State survey agencies any increased work. However, the draft of the new survey process states that it will require 40 percent more time. The States will not have 40 percent more Federal money or 40 percent more people August 1.

Even in my own State of Iowa, where I have approval to hire 23 new surveyors by July 1, and am ready to implement State training for the new survey process, I won't even be told who is qualified to be a surveyor or what professions make up a survey team until January 1, 1990. People I hire in July may not be qualified in January.

Survey procedures and guidelines have not been filed in the Federal Register and Code of Federal Regulations. I am told they do not intend to do so. Many interpretive guidelines found in the survey process establish standards which must appear as rules in order to be enforced. Further, the opportunity for public participation is absent when significant definition of standards is found in the Interpretive Guidelines and not filed as regulations.

Very important, also, is that with implementation of these new requirements must come new enforcement regulations. After August 1, the States will have no regulatory guidelines as to when to certify a faciiity or not.

Training of surveyors is of significant concern. The plans for training are to space it over a period of more than a year, with training taking place across the country during the Federal fiscal year 1990.

The survey process draft has not been validated as OBRA requires. Interestingly, concurrent with this push for new requirements by August 1 is the fact that HCFA has missed every single other implementation date so far. Where OBRA requires the Secretary to give guidance to States, there has been none.

Most distressing has been the preadmission screening and annual resident review for mental retardation and mental illness. We are now in receipt of a fourth manual issuance on how to implement PASSAR; regulations are still to follow.

We have manual material on nurse aide training received in April but we still have no guidance whatsoever on nurse aide registry. We are told that regulations will follow in 9 to 12 months and that they may not look like the manual issuance. Needless to say, this is a very difficult position for the States to be in, required by law to implement a program without regulatory guidance.

We would advocate, one, that the August 1 date be pushed back to October 1990, as is required by OBRA; two, that the matters we have responsibility for, such as PASSAR and nurse aide training, receive their first and primary attention and that we receive regulations; three, that consideration be given to amending implementation dates under OBRA so that this legislation can be implemented in a thoughtful, planned manner; and four, we believe that a national oversight committee appointed by the Secretary would be appropriate to oversee implementation of OBRA. Legislation this profound must have thoughtful direction if we are to realize our vision of high quality health care for the Nation's elderly and disabled.

Thank you.

The CHAIRMAN. Thank you, Dana. Your full statement will be included in the record.

[The prepared statement of Ms. Petrowsky follows:]

Mr. Chairman, members of the Committee, my name is Dana Petrowsky, and I am the Administrator of the Division of Health Facilities in the Iowa State Department of Inspections & Appeals. I am proud to be here today representing the State of Iowa, the Association of Health Facility Licensure and Certification Directors and the Association of State and Territorial Health Officers.

I have been certifying nursing homes for participation in the Medicare and Medicaid Programs since 1975, 14 years I have seen the growth of the Nursing Home Industry as well as the profound effect of the federal certification program on improving the quality of care and services in the nation's nursing homes. There can be no doubt that the federal program was the impetus for not only the growth, but also improved care and services provided.

The contribution of this Committee toward that improvement in care and services had been instrumental. The creation of this Committee in 1961 was the beginning of a responsible look at what the conditions were in this nation's nursing homes starting with the Moss Sub-Committee Hearings on Long Term Care in 1965. We are all familiar with the famous report of the Moss Sub-Committee in 1974, Nursing Home Care in the United States: Failure in Public Policy, outlining the problems with nursing home care and standards enforcement. The Committee held hearings spanning the years 1969 to 1973.

I was privileged to be here in July 1982, when this Committee held a hearing entitled Nursing Home Survey and Certification: Assuring Quality. I accompanied the Iowa Commissioner of Public Health who testified before this Committee of the need for a strong federal presence to enforce minimum standards. I also was a member of the Committee on Nursing Home Regulation at the National Academy of Science, Institute of Medicine which produced the report, Improving the Quality of Care in Nursing Homes. It was the basis of OBRA '87, Nursing Home Reform.

Being a Committee member was a privilege. The Committee was made up of distinguished professionals who have devoted their professional lives to the issue of quality health care. The Committee's report was nearly unanimously acclaimed as an important, credible piece of work. I want to acknowledge Congress and the leadership of the members such as yourselves that allowed that Committee report to be enacted almost totally into law within the following year.

The awesome promise of Nursing Home Reform is now before us and we now are challenged to develop a workable framework for its implementation. The importance of the work being done now cannot be overstated. Since 1975, there has been discussion that changes in the federal standards were necessary. It had taken 14 years to get to the point that we will actually see new standards. Once this new system that we are developing today is in place, my concern is that it will be another 14 years to see modifications. Therefore, let us be vigilant to develop a system that assures high quality health care to all beneficiaries of the entitlement.

The process I am seeing taking place causes me to worry. The vision laid out by the Committee and enacted by Congress cannot be realized without careful regard for their recommendations.

Let me make it very clear here today, that the States stand firmly behind the goals of nursing home reform. We are ready to uphold our side of the Federal - State Partnership in assuring high quality health care. We would like to, here today, acknowledge the staff of HCFA for their openness in developing the implementing regulations and procedures and using a process which promotes participation by the states. This is an improvement over the past that should not go without comment.

Also, I would like to acknowledge the commitment that we have seen on the part of numerous staff in HCFA to developing a viable system of quality assurance. Their many hours of work are to be applauded and we do so here today.

The clear intent of Congress was that they wanted reforms and they wanted them implemented soon. This was demonstrated by (1) the specificity of the legislation, (2) the implementation dates which were established, (3) the exemption from the paper work reduction act, (4) and the requirement that states are obligated to act whether or not the Secretary fulfills his responsibility to give direction to the states. The amount of work to implement an Act this comprehensive is massive. The inter-dependence of all the various pieces requires the precision of a maestro conducting a symphony.

What we have now is warm up before the concert and it looks and sounds like massive confusion and noise. Of greatest concern to the States is the slated implementation of the new "requirements" for Skilled Nursing Facilities and Intermediate Care Facilities, on August 1, 1989. This is ill advised and premature.

It is going to further chaos in a system already under stress. The reasons why implementation of the new requirements and survey procedure should be pushed back to October, 1990, as is required in the Act are:

1. The lynch pin of the new survey process is the mandatory, uniform resident assessment. This will not be ready until October, 1990.

2. OBRA '87 does not require the new survey and regulations until October, 1990.

3. In the February 2, 1989 Notice of Final Rule Making Regulatory Impact Statement "Effect on the States", it said that these new standards will not cost the State Survey Agencies any increased work. However, the draft of the new survey process states that it will require 40% more time. The States do not have 40% more people August 1, nor do we have 40% more federal money August 1. Many states must have a lead time of a year or more in order to receive permission to hire through the state budget process after receiving official notice from the federal government.

   Even in states like Iowa, my own state, where I have approval to hire 23 new surveyors July 1, 1989, and am ready to implement state training for the survey process, we won't even be told who is qualified to be a surveyor, or what professions would make up a survey team, until January, 1990. People I hire in July, may not be qualified in January.

4. Not insignificantly, Federal Judge Matsch, District of Colorado, ordered Secretary Bowen in the matter of Smith vs. Bowen to file survey procedures and guidelines in the Federal Register and Code of Federal Regulations. This has not been done. I am told they do not intend to do so. Many interpretive guidelines found in the survey process establish standards which must appear as rules in order to be enforced. Further, the opportunity for public participation is absent when significant definition of Standards is found in the Interpretive Guidelines and not filed as regulations.

5. Very important also is that with implementation of these new "requirements" must come new reinforcement regulations. Because the old regulations are based on a Condition of Participation format, which will no longer exist after August 1, 1989, the States will have no regulatory guidelines as to when to certify a facility or not certify a facility.

6. Training of surveyors is of significant concern. In order for the promise of new standards to be realized, there must be adequate training of the surveyors. The plans for training are to space it over a period of more than a year, with training taking place across the country during federal fiscal year '90.

7. The survey process draft to measure compliance with these new requirements have not been validated. OBRA specifically requires it. I am told by HCFA staff that they have a plan to do so. It seems that it is appropriate to develop a survey process in a more orderly fashion than to mandate National implementation, then to test and modify it. Thereby, requiring another re-training effort.

8. MMACs computer software to manage the survey process will also not be ready August 1.

Concurrently with this push for new requirements for SNF's and ICF's August 1, 14 months ahead of the OBRA scheduled implementation, is the fact that HCFA has missed every single implementation date so far where OBRA requires the Secretary to give guidance to the states in OBRA implementation. Most distressing has been the Pre-Admission Screening, Annual Resident Review for Mental Retardation and Mental Illness. We are now in receipt of a fourth manual issuance in how to implement PASSAR, this isn't draft regulations, it's draft manual material, regulations will follow.

Similiarly with Nurse Aide Training and Registry, we now have manual material on nurse aide training received in April. We have no guidance what so ever on the registry. We are told that regulations will follow in 9 to 12 months and they may not look like the manual issuance. Needless to say, it is a very difficult position for the states to be in, required by law to implement a program without regulatory guidance and the probability that whatever we do may not be what the regulations ultimately require.

Enforcement procedures under OBRA are of great concern and interest to the Association of Health Facility Licensure and Certification Directors. The terms used in the IOM Committee report are Enforcement and Sanctions. Because the term in OBRA is Remedies, the HCFA interpretation is that Congress meant to fix facilities rather than terminate them. This was not the intent of the Committee. We meant for the state survey agencies to have options in addition to termination for situations that did not call for drastic action but were related to the patient's health and safety. Further, it is clear in the report that we intended state survey agencies to have enforcement options.

HCFA's current plan for Remedies is that HCFA had enforcement responsibility based on the following logic: The Act delegates to the states the duty to certify Medicare facilities. The Act states the Secretary shall use remedies. They operate on the principle that in dually certified (Medicare and Medicaid) facilities, Medicare is lead over Medicaid. Hence, most enforcement options will be exercised by HCFA, presumably through the Regional Offices.

It is the position of the Association that the authority to levy sanctions should be delegated to the states via the contracts signed between the states and the Secretary. There should be federal oversight and monitoring of the program and the program should be operated using federally prescribed procedures. We believe the states are best equipped to do this because:

1. States have experience in administering these sanction programs.
2. It will be more efficient as states are closer to the process. Hearings would be easier.
3. This would avoid duplication with existing state programs.
4. It allows overall management of an enforcement system.
5. It minimizes the time between identification of the problems and taking action to address it.

We would advocate that the August 1, 1989 implementation date of the new requirements be pushed back to October, 1990, as stated in OBRA. That the matters we do have responsibility for now such as PASSAR and Nurse Aide Training and Registry receive primary attention so the states can receive some direction in how to proceed by regulations being implemented. That consideration be given to amending implementation dates under OBRA so that this important legislation is implemented in a thoughtful, planned manner.

We believe that a national oversight committee appointed by the Secretary would be appropriate to oversee implementation of OBRA. Legislation this profound must have thoughtful direction if we are to realize our vision of high quality long term care health care for this nation's elderly and disabled.

The CHAIRMAN. Dana, I would like the record to note that I believe you testified before this same committee in 1982 on some of these matters and we appreciate your coming back.

Our last witness on this panel is Kenny Whitlock, the Deputy Director, Division of Economic and Medical Services, Arkansas Department of Human Services. Kenny, we appreciate your being here.

STATEMENT OF KENNY WHITLOCK, DEPUTY DIRECTOR, DIVISION OF ECONOMIC AND MEDICAL SERVICES, ARKANSAS DEPARTMENT OF HUMAN SERVICES

Mr. WHITLOCK. Thank you, Mr. Chairman and members of this committee. I appreciate the opportunity to be here and the opportunity to express some of the problems that State administrators have had in trying to implement the provisions of OBRA 1987 nursing home reform.

Mr. Chairman, since my written comments will be a part of the record, I would like to deviate and get right to the bottom line, if I might.

The fact is that States have been asked to implement programs based upon a written law without the benefit of written regulations. In doing so, States have two things that occur—one, they take a financial risk because they expend money in developing programs which may later be determined to be inadequate to meet the conditions of the final regulations; and two, the other choice they have is that they can violate the law. Those are not good choices that bureaucrats like myself like to choose between.

In addition to the financial risk, which this has caused, it has also caused us in the State of Arkansas to probably hurt our residents in our nursing homes. The reason I say that is because we have chosen to try to implement the provisions of the law without the benefit of the regulation. In other words, we've gone ahead with the PASSAR provisions on January 1. There have been four drafts that have been submitted and each of those drafts has been significantly different, as you pointed out in your opening statement. The result of that is that residents and members of their families do not know whether or not their family member is going to have to leave a nursing home, go to another facility, or not. Each time we get a different draft we have to inform people that we're handling these provisions in a different manner.

Therefore, there's a great deal of anxiety that's built up among our residents and members of their families. To that extent, our neighboring State of Texas did challenge the law and has not implemented those provisions effective January 1, and I'm not too sure they didn't do their clients a favor in doing so.

We are making efforts to try to comply with this law, not simply because the law says so, but because we think it's the most significant nursing home reform provisions since the inception and the passage of Title XVIII and Title XIX. It is important that we do this.

The message I would like to leave this committee is that we must implement the provisions of this law. It is not a matter, as everyone has stated before, of whether we do it or not, it is a matter of

how and when we do it. It has got to be done. In fact, it is 20-plus years overdue. We need it done and we need it done now. In the State of Arkansas, we're committed to making that happen but the way that this has been established, the States are at great financial risk. Residents of nursing homes are also in a very precarious position. We would ask that this committee consider those recommendations which have been made to delay—and I like the way Senator Heinz put it—not really delay but proceed in an orderly manner. We strongly suggest that we do just that.

I thank you very much for the opportunity to be here today.

The CHAIRMAN. Thank you very much, Ken. Your full statement will be placed in the record.

[The prepared statement of Mr. Whitlock follows:]

TESTIMONY BEFORE THE U. S. SENATE SPECIAL COMMITTEE ON AGING'S HEARING ON THE FEDERAL GOVERNMENT'S ROLE IN THE IMPLEMENTATION OF THE NURSING HOME REFORM PROVISIONS OF OBRA 1987 BY KENNY WHITLOCK, DEPUTY DIRECTOR OF ECONOMIC AND MEDICAL SERVICES, ARKANSAS DEPARTMENT OF HUMAN SERVICES

The Division of Economic and Medical Services of the Arkansas Department of Human Services supports the provisions of the Omnibus Budget Reconciliation Act of 1987 and applauds the efforts of Congress in passing widespread nursing home reform mandates. These reforms will help ensure quality of care services to all citizens who reside in our nursing homes. However, since the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1987, the Health Care Financing Administration (HCFA) has been slow in responding to the mandates and time frames specified in the OBRA legislation. While HCFA has been responding to comments from various groups and organizations across the country, the delay in implementing specific provisions of OBRA has caused a great deal of confusion for the States in trying to implement the massive provisions of OBRA. For the purpose of this paper and presentation, I will limit my comments to three specific areas of the provisions of OBRA. These are: Nursing Home Aide Training, Pre-admission Screening and Annual Resident Review (PASARR) and Medicare and Medicaid Requirements for Long Term Care Facilities.

o Nursing Home Aide Training

Section 1919 (f) list the responsibilities of the Secretary relating to nursing facility requirements. In Section 1919(f) there is specific language that specifies that the Secretary shall establish, by not later than July 1, 1988 the following:

1. Requirements for the approval of nurse aide training and competency evaluation programs including the areas to be covered in such a program, minimum hours of initial and ongoing training and retraining, qualifications of instructors and procedures for determination of competency;

2. Requirements for the approval of nurse aide competency evaluation programs; and

3. Requirements specifying the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs.

As of this date, HCFA has not issued any final rule specifying the above requirements. Several drafts have been developed and forwarded to various groups and organizations for comment. However, these drafts lack any formality and often change from issuance to issuance without any consistency. This places the states in the position of trying to implement an effective aide training program without direction or guidance from HCFA. Thus, the burden of meeting the OBRA provisions is on the states not HCFA.

Arkansas has approximately 7,000 nursing home aides who are currently employed but who did not meet our requirement for deeming eligibility. Therefore, these 7,000 aides must pass a competency evaluation program before December 31, 1989 or they will no longer be permitted to work in any nursing facility. Since HCFA has not issued regulations or guidelines for states to follow, we may have a vast number of these aides go through a competency evaluation program only to find out later the program did not meet HCFA requirements. We have estimated that each competency evaluation (a written or oral test and a skills evaluation) will take approximately one hour per aide. This means a total of 7,000 man hours in administering the evaluations plus time for grading, travel from site to site, etc. If we are to have all 7,000 aides evaluated by December 31, 1989, we must begin the competency evaluations no later than June 1, 1989. Yet, HCFA officials are stating it may be as late as October, 1989 before a final regulation on aide training is issued.

In addition, there are a large number of private firms and organizations that want to participate in the competency evaluation and testing program. In order to meet the requirements of Arkansas law, we must open this program to competitive bids. Based on our own Administrative Procedures Act, the bid must be released and a 30 day period is given to all bidders. The bids must be reviewed and awarded. This process could take as long as 90 days and would move the implementation date to August or later. This could make it impossible to have all current employed aides certified by December 31, 1989.

o Pre-admission Screening and Annual Resident Review (PASARR)

Section 1919(f)(8) specifies that the Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under the pre-admission screening and annual resident review and shall notify the States of such criteria.

States have been required to develop their own pre-admission screening criteria and to pre-screen persons with MI/MR diagnoses since January, 1989. Due to the number of draft regulations and differing opinions and interpretations given by HCFA personnel at both the regional and central offices, these requirements have varied greatly from state to state. As of this past week, HCFA has issued the fourth draft of the PASARR requirements. The fourth draft is vastly different from all previous drafts and makes significant changes in the way States must implement the pre-admission screening for persons with a diagnosis of mental illness or mental retardation. The fourth draft changes the requirements on the admission of persons with a MR/MI diagnosis and allows nursing facilities to admit such persons as long

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as the provisions of active treatment are met, largely at state expense. This is a major change in the process since prior PASARR drafts mandated that States not admit or retain such persons even if the facility could provide active treatment. Persons who required nursing home care but also required active treatment were not appropriate for admission or continued stay except under four limited exceptions which did not apply if the person was considered to be a danger to self or others (potentially assaultive or self abusive).

While the previous draft guidelines make provision for persons continuously residing in the facility for 30 months or more who needed active treatment, the previous drafts were unclear if residents of a nursing facility were permitted to return to those facilities after an extended admission to a hospital for acute psychiatric care. A number of residents in Arkansas who were admitted to hospitals for acute psychiatric illness were not placed back in the nursing facility due to a need for active treatment for the MI/MR diagnosis and the fear of potential danger to self or others. However, the fourth draft allows these individuals to remain in the nursing facility as long as the provision of active treatment is met. Potential danger to self or others is not addressed except for persons of advanced years who choose not to receive active treatment.

Does this mean we should now move these residents back to their former nursing facility if that facility provides active treatment? If so, was it really necessary to move them or exclude them in the first place. The movement of residents back and forth based on the latest HCFA draft appears to be a violation of residents rights. Will the final regulations require moving them out again? During this transition period when the PASARR law and the HCFA draft regulations have appeared to be in conflict, and attempts of clarification by HCFA staff have often added to the confusion, states and providers have been at risk of potential disallowances for not not properly implementing pre-admission screening. The tragedy is the providers and the states have tried to implement the changing HCFA requirements as we understood them, and the resident has suffered. In most cases, this uncertainty has caused many residents to be even more confused, and such movement from one location to another is detrimental to the resident. Residents would have been better served if the states had implemented the law as they understood it, and not tried to follow the instructions in 1st, 2nd, 3rd, and now 4th drafts of PASARR regulations. Since the fourth

draft by HCFA is so vastly different from all previous drafts, do we implement now or wait on the final regulation which should have been issued by October 1, 1988? Texas and a number of other states have elected to block PASARR by filing an injunction against HCFA. The final outcome of these lawsuits has not been determined but it appears their actions were better suited to the needs of the residents than those of us who tried to implement and as a result moved residents.

As a final comment on the PASARR requirements, we strongly urge that states should not be penalized for trying to implement the provisions of OBRA by making good faith efforts to provide a pre-admission screening program.

o Medicare and Medicaid Requirement for Long Term Care Facilities

Unlike Aide Training and PASARR, HCFA has issued final regulations changing the Medicare and Medicaid requirements for long term care facilities. These regulations become effective August 1, 1989 and are a massive reform of previous regulations.

The concern regarding the Medicare and Medicaid requirements for long term care facilities is the accelerated implementation phase not so much the regulations themselves. Officials at HCFA have stated that the forms, procedures, policies and guidelines used by surveyors in all states will not be ready by August 1, 1989. These will follow at a later date. Our concern is how can states implement a new survey process with new regulations without implementing procedures, forms and guidelines for the surveyor in the field?

The purpose of this testimony is not to be overly critical of HCFA officials but to strengthen the position of the States in their concern that implementation of some aspects of the OBRA legislation should be delayed until such time HCFA has issued final regulations. The States are being placed in a position of being held financially liable for the failure of HCFA to issue regulations, guidelines and policy regarding a large number of issues without final regulations. States have made a good faith effort in complying with the intent of OBRA and should not be held accountable for situations over which they have no control.

The CHAIRMAN. Kenny, was the February rule announced by HCFA a surprise to the States? For example, was it a surprise to the State of Arkansas?

Mr. WHITLOCK. Senator, I can't say that it was a surprise. I think that in terms of the aides training provisions, we have been very much out on a limb in that respect because we have issued an RFP for a contract and we're doing it on the hope that it will meet the Federal requirement.

In terms of the licensing survey rules, in that aspect, if we had the guidelines for our staff in the field, we could implement. But my understanding is that those aren't going to be available in August when this new regulation takes effect. Without those, we're lost and, in my opinion, cannot implement.

The CHAIRMAN. Then let me ask this question once again on the subject of surprises. Were the States surprised when HCFA failed to meet 10 deadlines as mandated by OBRA 1987?

Mr. WHITLOCK. Mr. Chairman, I was not surprised because of the complexity of OBRA. While we did expect a better effort, I think, in meeting them, we did not expect four final drafts on the PASARR regulations. I can't say that we really expected them to meet those timeframes.

The CHAIRMAN. Let's go back to the February Rule announcing an August 1 implementation date for much of it. Were the States consulted by HCFA as to their respective budget cycles? I know what the budget cycle is for the State of Arkansas. Now, I can only assume that our very fine Governor down there, Governor Bill Clinton, would have to call a special session of the legislature to find either the necessary money or to maybe change the law in some respects. Is this correct?

Mr. WHITLOCK. Yes, sir, it is correct. However, we did attempt to anticipate, based on the language in the law, when we constructed our biannual budgets this past spring, the necessary personnel that would be required and the additional money that would required to implement some of these provisions. A lot of that, as I say, depends on what the final regulations look like and we're out on a limb in that respect because we still don't know what it is going to entail.

The CHAIRMAN. Dana, let me ask you a question and then I will yield to Senators Cohen and Shelby.

There is a great dispute between the States and the Federal Government as to who will be responsible for enforcement—who is going to level the fines, who's going to assess the penalties. You were on the Institute of Medicine panel; what was the recommendation of this panel?

Ms. PETROWSKY. Clearly, the intent of the committee was to beef up the State's artillery so that they had more things that they could use to bring facilities into compliance. It is the States that are out inspecting these facilities on a daily basis and they're the ones closest to the action.

The CHAIRMAN. What is HCFA's position?

Ms. PETROWSKY. HCFA's position is an interesting construction of the act, and that is they've interpreted that it is reserved to the Secretary, which means, I presume, that the regional offices will do all of the sanctioning. I can see regional offices with hundreds and hundreds of sanctions going through——

The CHAIRMAN. In dealing with the HCFA representatives, do you sense that they desire this responsibility?

Ms. PETROWSKY. We certainly would question their interpretation of the act. If the act needs to be clarified, I certainly would advocate it, because it certainly should be reserved to the States. The States have experience, it would allow for the State programs to be coordinated with the Federal program for sanctioning, and it just makes abundant sense to leave it to the States.

The CHAIRMAN. Do you think the States would be as tough or tougher in advocating for the nursing home residents vis-a-vis HCFA? Who do you think could better enforce the intent of the Congress?

Ms. PETROWSKY. I think that the Federal Government should give guidance to the States in how to conduct the program, oversee the States, monitor the States, but it should be a Federal program with Federal oversight.

The CHAIRMAN. But the States should be the enforcement agencies?

Ms. PETROWSKY. Be the soldiers, yes.

The CHAIRMAN. Thank you.

Senator Cohen.

Senator COHEN. Thank you, Mr. Chairman.

I'm told that of over a hundred interested parties who offered comments on the residents' rights regulations proposed by HCFA in October 1987 almost half of them strongly supported elevation of the residents' rights to a "condition of participation." Now with the publication of the final regulations on February 2, 1989, HCFA has done away with the term "condition of participation." How do you interpret this? What do you take this to mean?

Ms. PETROWSKY. I take them at their word that they mean that all of the requirements are to be met and if they are not they're to be sanctioned. The new survey process, as I've seen it, puts great emphasis on residents' rights, with the surveyors directed to do a 30 minute interview with 20 percent of the residents around the rights issue.

Senator COHEN. Mr. Whitlock, do you have any comment?

Mr. WHITLOCK. Senator, in our State we have incorporated the provisions of the bill of rights also into State law. We will be monitoring it from both the Federal provision as well as from our State law, which requires certain penalties for failure to comply.

Senator COHEN. Do you share Ms. Rhodes' understanding--this is really just a question not of commitment on the part of HCFA but perhaps one of coherency? In the regulations, I suppose as in life and love, timing is everything and there seems to be a serious problem of timing, of misfiring, of being late, and then coming back with a surge at the wrong time, creating kind of a push me-pull you type of atmosphere within the nursing home industry. Do you share that view that we're on the right track? That HCFA, in fact, is trying to achieve the goals that were set with the passage of the legislation?

Ms. PETROWSKY. I see evidence that they're trying to do what they have to do. They have an overwhelming task, there is no doubt about it. It is interesting why they chose to emphasize the areas they did instead of the ones that the act requires. They spent

a great deal of time on the HCFA data release, they spent a good deal of time on these new requirements, yet they haven't spent the time that the law would require on the earlier pieces.

Senator COHEN. Mr. Whitlock.

Mr. WHITLOCK. Senator, I would say that in this process they have been more open than at any time that I can remember. They have been willing to talk to us, they've tried to help us, and in some ways that's been a mixed blessing—as pointed out earlier by the Chairman, without the regulations, we would have a blessing. In this case, they have been open, they have provided us with a lot of assistance. However, it is like a roller coaster; there just isn't any consistency. I suppose that's inevitable when you're looking at legislation of this magnitude and they're trying to write regulations that's going to be required to implement it.

Senator COHEN. What about Senator Heinz' suggestion that perhaps what we should do is delay the implementation of the regulations, carving out one exception dealing with nursing home patients' bill of rights? Does that make sense even though it may be inconsistent with what we're doing elsewhere?

Mr. WHITLOCK. Senator, I would agree with that as probably the best scenario. The only other suggestion that I could possibly make would be that States be given some flexibility in terms of good faith effort and not be held liable for failure to comply with the final regulations when they finally do come out. The only reason I mention that is because it is late, it is 20-plus years too late, and these provisions need to be effective. However, I think that Linda's comments earlier regarding an organized approach to dealing with this so that we have an effective program is probably the best course of action.

Senator COHEN. Thank you very much.

The CHAIRMAN. Thank you, Senator Cohen.

Senator Grassley.

Senator GRASSLEY. Thank you very much, Mr. Chairman.

If, because I was gone, these questions have in any way been answered, just say I can read that on the record, because I don't want to take any time of the committee if you've already been over this.

My first question deals with questions of costs to the States. The States are required to provide active treatment for those who the OBRA screening process finds to be in need of such treatment. How much is this requirement to provide active treatment going to cost your respective States, but I'm primarily interested in the State of Iowa, and where will they get the money for doing this?

Ms. PETROWSKY. That's a very significant question. It has not been asked. We're told now that active treatment is not reimbursable under the program and yet facilities are told that they have to meet the individual's needs. As you know, individuals who have been in the facility 30 months prior to implementation can stay in the facility. There are other provisions of the entitlement that can cover services but it cannot be under the facilities per diem, so we are told. So there is an obvious conflict.

Senator GRASSLEY. So, basically, in my State, where nursing home operators are reimbursed for Medicaid patients by 64 percent—I think under the new State appropriation, will be reim-

bursed at about 74 percent—then that means the private pay patients are going to pay for this cost, is that right?

Ms. PETROWSKY. That's been the history.

Senator GRASSLEY. That's been the history? OK.

Would you have any comments, sir?

Mr. WHITLOCK. Senator, only that in the fourth draft regarding the PASARR provisions, the description of treatment is so comprehensive and requires 24-hour accessibility, it almost means that a nursing home would have to qualify as an ICFMR or as a psychiatric facility in order to be able to meet the requirements of the treatment. I think it will be extremely expensive unless we have a draft five.

Senator GRASSLEY. OK. I understand that Iowa submitted an alternative disposition plan. Are you familiar with that?

Ms. PETROWSKY. Vaguely, yes.

Senator GRASSLEY. OK. The summation of this plan means, does it not, that the State of Iowa assumes or knows that it does not have available alternative placement for individuals who will be displaced from nursing homes or will not get into nursing homes although they need treatment?

Ms. PETROWSKY. I'm not familiar with the specifics, but I do know that it is a plan to allow them some time to come up with alternatives.

Senator GRASSLEY. Maybe you aren't familiar enough with the plan then to answer my concern about how these people will be handled. How is it laid out in the alternative plan?

Ms. PETROWSKY. I don't know.

Senator GRASSLEY. Maybe I could ask you to submit that answer in writing for the record. Would you do that, please?

Ms. PETROWSKY. I would.

[Subsequent to the hearing, the following information was received:]

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

DIVISION OF MENTAL HEALTH, MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES

September 29, 1989

U.S. Senate
Special Committee on Aging
G-31 Dirksen Senate Office Building
Washington, D.C. 20510-6400
ATTN: Ms. Holly Bode

Dear Ms. Bode:

This letter is to respond to questions posed by Senator David Prior in an August 23rd letter to Ms. Dana Petrowsky of the Iowa Department of Inspections and Appeals concerning the provision of "active treatment" to residents of nursing facilities in Iowa and the type of care available in Iowa for persons displaced from or prevented from entering nursing facilities due to preadmission screening and annual resident review (PASARR) requirements. I have spoken with Ms. Petrowsky concerning these questions. As the Department of Human Services, Division of Mental Health, Mental Retardation, and Developmental Disabilities is Iowa's mental health and mental retardation authority and is responsible for administration of the PASARR process in Iowa, I have agreed to respond to these questions.

The first group of questions relates to the provision of "active treatment" to those whom the PASARR process determines to be permitted to stay in nursing facilities and receive services. How much is this treatment going to cost in the state of Iowa? Where are we going to get the money for this requirement? Since the state of Iowa has been screening nursing facility applicants and residents for medical need for the past ten years, we anticipated and our initial assessments have indicated that most persons residing in nursing facilities in the state require nursing facility level of care for a medical need. Thus, we anticipate that many of the persons identified as having service needs related to a mental illness or mental retardation will be most appropriately served in existing nursing facilities with the provision of additional services to deal with their mental illness or mental retardation. We are in the process of analyzing what the cost of these services will be, but as this process is not complete I cannot provide a dollar amount at this time. We anticipate that provision of these services for Medicaid recipients will be an additional cost to the county, state and federal medicaid budgets. Services to private pay residents of nursing facilities would be an additional cost to the individual, their family, or their insurer.

The second group of questions relates to what type of care is available in Iowa now for those persons whom PASARR will either displace or prevent from entering a nursing facility? What is contained in Iowa's Alternative Disposition Plan (ADP) to address those needs? Does Iowa have any system in place to keep track of those persons who are diverted from nursing homes? Care for those persons whom PASARR will either displace or prevent from entering a nursing facility due to a mental illness is presently provided to an average of 90 persons in the geriatric psychiatric units of the state Mental Health Institutes. As this component of the mental health care system is currently fully utilized and not appropriate for all nursing facility residents who need an alternative placement due to a mental illness, we are considering developing 150 skilled nursing facility beds for persons with a mental illness by 1994. These beds would be located in state-run facilities and would cost approximately 5.6 million dollars. For persons with mental retardation, care is presently provided at the intermediate care facility for persons with mental retardation (ICF/MR) level at the State Hospital Schools or in private ICF/MR facilities. It is anticipated that some nursing facility residents who need an alternative placement due to mental retardation will be served in existing private ICF/MR facilities.

As the assessment process developed in Iowa for nursing facility applicants and residents allows us to identify the placement of specific individuals in the system who complete the evaluation and determination process, keeping track of persons in this group does not present a problem. However, persons who do not complete the evaluation and determination process for some reason are presently lost to our tracking system. We are currently analyzing this population group to determine the extent of this problem. If this group consists of significant numbers of persons, we will have to augment the system to track persons in this group.

Thank you for the opportunity to provide you with this information. If you have questions concerning our response, please feel free to contact Bill Dodds, Iowa Department of Human Services, Division of MH/MR/DD, Hoover State Office Building, Des Moines, Iowa 50319, (515) 281-6873.

Sincerely,

Sally Titus Cunningham
Acting Administrator

STC/bd

cc: Dana Petrowsky

Senator GRASSLEY. Thank you very much.

Mr. Chairman, I have no more questions.

The CHAIRMAN. There are no more questions. We thank you for coming and participating. I believe you've added a lot to the hearing.

We're going to now call the third panel: Dr. Ross Anthony, Associate Administrator for Program Development, Health Care Financing Administration, who will be accompanied by Mr. Tom Hoyer.

Gentlemen, if you would come forward.

We have a special request from this witness. His statement is 7 minutes long—and since he's suffered all these allegations and accusations, and has been publicly flogged—without objection, I'm going to give him 7 minutes.

STATEMENT OF DR. C. ROSS ANTHONY, ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY TOM HOYER

Dr. ANTHONY. I appreciate it. I would only note that a few people said some nice things, too.

The CHAIRMAN. Yes, they certainly did.

Dr. ANTHONY. Mr. Chairman and members of the committee, I am pleased to have this opportunity to discuss the Federal Government's role in implementing nursing home reform. There is no more important consideration to Secretary Sullivan and the Health Care Financing Administration than assuring that the elderly, sick, and disabled receive quality health care in our Nation's nursing homes. This group is among the most vulnerable, because of failing health which requires them to be cared for in institutional settings.

The members of this committee have been deeply involved with nursing home care and committed to nursing home reform for many years. Because of this involvement, you know its history and how we've reached this point. I want to focus on what's happened since 1986 when the Institute of Medicine released its study on how to regulate nursing homes. The Institute of Medicine confirmed what those of us in the health care community knew—namely, that there are thousands of excellent nursing homes in this country, but sadly there are many that did not meet minimum standards. For those residents living in substandard nursing homes, there was a pressing need to improve the quality of care. The real significance of the Institute of Medicine study was that for the first time, there was a consensus of experts on major aspects of Federal regulations, including such critical areas as resident rights, resident assessment, quality of care, and quality of life.

The next step was to implement the Institute of Medicine recommendations through regulations. The task, while conceptually simple, was extremely complex, as I think you've heard many instances of here today. For example, the Institute of Medicine recommended that there be a major set of Federal requirements dealing with the quality of life. Defining and translating this rather simple concept proved to be a challenge. It was HCFA's responsibil-

ity to establish standards that would serve residents effectively, nursing homes could implement, and inspectors could enforce.

Ultimately, the Institute of Medicine recommendations resulted in two proposed notices in 1987. The first concerned the requirements that nursing homes must meet to participate in Medicare and Medicaid programs. The second involved the processes that the Federal Government would employ to enforce compliance with these requirements. These regulations were the product of many months of collaboration, frequent meetings, and consultations with consumer and industry groups and congressional staffs to achieve as much consensus as possible on the content of the regulations.

At the same time Congress, too, had been studying the need for nursing home reform and enacted, in December 1987, legislation known as the OBRA 1987 legislation to deal with this issue. We shared the common goal of improved nursing home quality as expressed in the administration's draft rules, but there were some important differences in the OBRA 1987 legislation which required that additional regulations be promulgated beyond those we had in process.

The differences and expansions presented HCFA with a dilemma—we had already promulgated draft regulations that contained many of the same requirements contained in the legislation, particularly in the requirements long-term care facilities must meet to participate in Medicare and Medicaid. However, the law now required regulation in new areas.

One option was for HCFA to scrap the pending draft rules and go back to the drawing board. We did not want to delay such important areas of reform as enhanced residents' rights and strengthened quality of care. And I'll be glad to get into those in detail. We've been accused of going forward with those and, frankly, I'm proud that we did.

Thus we decided to go forward wherever possible and move full speed ahead with nursing home reform. We studied the legislation, determined what was still valid from our proposed regulation, and what new issues and areas would need regulations. On February 2 we published final regulations—with a comment period so people would have a chance to comment on it—that revise and consolidate the requirements that facilities furnishing long-term care must meet to participate in both the Medicare and Medicaid programs.

I might add, Mr. Chairman, that HCFA was lobbied hard on this decision to go forward, with opinion among the various interest groups divided.

Publication of this regulation was the beginning of nursing home reform. OBRA's new authorities require us to promulgate new regulations to address new survey and certification requirements and enforcement mechanisms. Our staff has been working hard on these areas, which I will address later in my testimony.

Let me address the process we adopted for developing nursing home reform regulations, one which is still underway. Because of the widespread interest in these regulations, we consciously adopted a process of consultation. You've heard that from the witnesses already. This decision might have delayed issuance of regulations, but we believe a deliberate and careful process of consultation is essential to the success of nursing home reform.

Our requirements for long-term facilities focus on facility performance and resident outcome rather than on procedural or paperwork requirements. The object of our regulation is to require that a facility provide each resident with the necessary nursing, medical, and psychological services to maintain or enhance the quality of care for each resident. To highlight one important feature, the Residents' Bill of Rights is included in our regulations and addresses, among other things, the residents' right to free choice of personal attending physician and the right to be fully informed in advance about care and treatment.

We are drafting proposed regulations for a number of major OBRA 1987 changes that must be implemented on October 1, 1990, and will be published in the next several months. They include requirements for nurse aide training and competency evaluation and registry requirements, preadmission screening and annual resident review requirements, appeals for transfer and discharge decisions and decisions made in the PASARR process, State notices of Medicaid rights, Federal standards for monitoring State waivers of nurse staffing requirements, administrator standards, and items and services not chargeable to patient funds. It's a daunting list, frankly.

During the time of developing these additional regulations, HCFA provides advice to States through manual instructions to give States guidance in certain areas before regulations are final. Preadmission screening and nurse aide training and competency evaluation program manuals and instructions, for example, have already been issued.

Many of the OBRA 1987 provisions are difficult to implement and cover extremely sensitive issues. There are many and often competing interests involved, from nursing home owners to consumers and both the State and Federal Governments. Our primary goal is to make sure that what we do is best for the Medicare and Medicaid nursing home patient.

As this committee knows, enforcement efforts in the 1970's focused on the safety of physical plant and sanitation. As I stated earlier, HCFA issued an NPRM in this area in the fall of 1987. Because of the major changes in the OBRA 1987 legislation, we decided to scrap that regulation and began development of a completely new NPRM on survey, certification, and enforcement.

We are consulting and sharing draft material with appropriate groups. We are proceeding as quickly as possible with other steps needed—for example, the minimum data set used for patient assessment is being developed and tested already. In the testimony, there is a long list of the various groups that we've consulted with, which, frankly, is just a partial list of all of the people we've been talking with.

I also want to emphasize that all requirements for certification must be met by nursing facilities. In the past, we used the condition of participation format that led to some misunderstanding that violations of lesser requirements would not be subject to Federal enforcement. We will no longer use the traditional "conditions" and "standards" terminology in our regulations. We want nursing facilities to recognize that all of the nursing facility requirements are binding and that all are important. At the same

time, we recognize that violations of these requirements, depending on type or severity, may be remedied through the different enforcement mechanisms available under statute to remedy the different kinds of violations of Federal certification requirements.

As part of our overall effort to improve the quality of nursing home care, in December 1988, we released detailed information on the populations and performance of each of the 15,000 nursing homes that participate in the Medicare and Medicaid programs. The publication, entitled "Medicare/Medicaid Nursing Home Information," consists of 75 volumes, with at least one volume for each State and the District of Columbia.

The CHAIRMAN. How much more do you have, Dr. Anthony?

Dr. ANTHONY. About 1 minute.

The CHAIRMAN. Thank you, sir.

Dr. ANTHONY. We intend to publish the nursing home information release annually.

I would like to conclude my statement by affirming our commitment to the Medicare and Medicaid beneficiaries who reside in nursing homes and who look to us to protect their rights and their needs. This protection has been our fundamental goal as we have developed policies to implement reforms in nursing home quality. We have sought the many, and often conflicting, points of view in the development of the final regulations; we continue to seek advice as we draft the rules for the OBRA requirements.

As I noted earlier in my statement, this deliberative process is, by its very nature, time consuming. We chose to take that time, rather than to rush through the process simply, to meet deadlines. To those who criticize us for proceeding too quickly with the publishing of the final regulations on February 2, 1989, I say that the need to protect the residents of nursing homes is pressing, and we should proceed with reform as quickly as possible. To those who say we are moving too slowly on OBRA requirements, I say that we are being thorough and open in our policy development process. I believe we will have a better product as a result. Clearly we have gained consensus in some areas; with others we will have to accept divided opinion among the interested parties. Our overriding objective against which we will measure our success will be the improvement in the quality of life of Medicare and Medicaid beneficiaries who reside in our Nation's nursing homes.

[The prepared statement of Dr. Anthony follows:]

STATEMENT OF

C. ROSS ANTHONY, PH. D.

ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

MAY 18, 1989

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM PLEASED TO HAVE THIS OPPORTUNITY TO DISCUSS THE FEDERAL GOVERNMENT'S ROLE IN IMPLEMENTING NURSING HOME REFORM. THERE IS NO MORE IMPORTANT CONSIDERATION TO SECRETARY SULLIVAN AND THE HEALTH CARE FINANCING ADMINISTRATION THAN ASSURING THAT THE ELDERLY, SICK, AND DISABLED RECEIVE QUALITY HEALTH CARE IN OUR NATION'S NURSING HOMES. THIS GROUP IS AMONG THE MOST VULNERABLE BECAUSE OF FAILING HEALTH WHICH REQUIRES THEM TO BE CARED FOR IN INSTITUTIONAL SETTINGS.

QUALITY OF CARE

THE MEMBERS OF THIS COMMITTEE HAVE BEEN DEEPLY INVOLVED WITH NURSING HOME CARE AND COMMITTED TO NURSING HOME REFORM OVER THE YEARS. BECAUSE OF THIS INVOLVEMENT, YOU KNOW ITS HISTORY AND HOW WE'VE REACHED THIS POINT. I WANT TO FOCUS ON WHAT'S HAPPENED SINCE 1986 WHEN THE INSTITUTE OF MEDICINE (IOM) RELEASED ITS STUDY OF HOW TO REGULATE NURSING HOMES. THE IOM STUDY CONFIRMED WHAT THOSE OF US IN THE HEALTH CARE COMMUNITY KNEW - NAMELY THAT THERE ARE THOUSANDS OF EXCELLENT NURSING HOMES IN THIS COUNTRY, BUT SADLY THERE WERE MANY THAT DID NOT MEET MINIMUM STANDARDS. FOR THOSE RESIDENTS LIVING IN SUBSTANDARD NURSING HOMES, THERE WAS A PRESSING NEED TO IMPROVE THE QUALITY OF CARE. THE REAL SIGNIFICANCE OF THE IOM STUDY WAS THAT FOR THE FIRST TIME, THERE WAS A CONSENSUS OF EXPERTS ON MAJOR ASPECTS OF FEDERAL REGULATION, INCLUDING SUCH CRITICAL AREAS AS RESIDENT RIGHTS, RESIDENT ASSESSMENT, QUALITY OF CARE, AND QUALITY OF LIFE.

THE NEXT STEP WAS TO IMPLEMENT THE IOM RECOMMENDATIONS THROUGH REGULATIONS. THE TASK, WHILE CONCEPTUALLY SIMPLE, WAS EXTREMELY COMPLEX. FOR EXAMPLE, THE IOM RECOMMENDED THAT THERE BE A MAJOR SET OF FEDERAL REQUIREMENTS DEALING WITH THE "QUALITY OF LIFE." DEFINING AND TRANSLATING THIS RATHER SIMPLE CONCEPT PROVED TO BE A CHALLENGE. IT WAS HCFA'S RESPONSIBILITY TO ESTABLISH STANDARDS THAT WOULD SERVE RESIDENTS EFFECTIVELY, NURSING HOMES COULD IMPLEMENT AND INSPECTORS COULD ENFORCE.

ULTIMATELY THE IOM RECOMMENDATIONS RESULTED IN TWO PROPOSED RULES PUBLISHED IN 1987. THE FIRST CONCERNED THE REQUIREMENTS THAT NURSING HOMES MUST MEET TO PARTICIPATE IN MEDICARE AND MEDICAID, AND THE SECOND INVOLVED THE PROCESSES THAT THE FEDERAL GOVERNMENT WOULD EMPLOY TO ENFORCE COMPLIANCE WITH THESE REQUIREMENTS. THESE REGULATIONS WERE THE PRODUCT OF MANY MONTHS OF COLLABORATION, FREQUENT MEETINGS, AND CONSULTATIONS WITH CONSUMER AND INDUSTRY GROUPS AND CONGRESSIONAL STAFFS TO ACHIEVE AS MUCH CONSENSUS AS POSSIBLE ON THE CONTENT OF THE REGULATIONS.

AT THE SAME TIME CONGRESS, TOO, HAD BEEN STUDYING THE NEED FOR NURSING HOME REFORM AND ENACTED IN DECEMBER 1987 LEGISLATION KNOWN AS THE OMNIBUS BUDGET RECONCILIATION ACT (OBRA 87). WE SHARED THE COMMON GOAL OF IMPROVED NURSING HOME QUALITY AS EXPRESSED IN THE ADMINISTRATION'S DRAFT RULES. BUT THERE WERE SOME IMPORTANT DIFFERENCES IN THE OBRA 87 LEGISLATION WHICH REQUIRED THAT ADDITIONAL REGULATIONS BE PROMULGATED.

THESE DIFFERENCES AND EXPANSIONS PRESENTED HCFA WITH A DILEMMA -- WE HAD ALREADY PROMULGATED DRAFT REGULATIONS THAT CONTAINED MANY OF THE SAME REQUIREMENTS CONTAINED IN THE LEGISLATION, PARTICULARLY IN THE REQUIREMENTS LONG-TERM CARE FACILITIES MUST MEET TO PARTICIPATE IN MEDICARE AND MEDICAID. HOWEVER, THE LAW NOW REQUIRED REGULATION IN NEW AREAS. ONE OPTION FOR HCFA WAS TO SCRAP THE PENDING DRAFT RULES AND GO BACK TO THE DRAWING BOARD. WE DID NOT WANT TO DELAY SUCH IMPORTANT AREAS OF REFORM AS ENHANCED RESIDENTS RIGHTS AND STRENGTHENED QUALITY OF CARE.

THUS, WE DECIDED TO GO FORWARD WHEREVER POSSIBLE AND MOVE FULL SPEED AHEAD ON NURSING HOME REFORM. WE STUDIED THE LEGISLATION, DETERMINED WHAT WAS STILL VALID FROM OUR PROPOSED REGULATION AND WHAT NEW ISSUES AND AREAS WOULD NEED NEW REGULATIONS. ON

FEBRUARY 2 WE PUBLISHED FINAL REGULATIONS (WITH A COMMENT PERIOD) THAT REVISE AND CONSOLIDATE THE REQUIREMENTS THAT FACILITIES FURNISHING LONG TERM CARE MUST MEET TO PARTICIPATE IN BOTH THE MEDICARE AND MEDICAID PROGRAMS. I MIGHT ADD, MR. CHAIRMAN, THAT HCFA WAS LOBBIED HARD ON THIS DECISION TO GO FORWARD, WITH OPINION AMONG THE VARIOUS INTEREST GROUPS DIVIDED. PUBLICATION OF THIS REGULATION WAS THE BEGINNING OF NURSING HOME REFORM. OBRA's NEW AUTHORITIES REQUIRE US TO PROMULGATE NEW REGULATIONS TO ADDRESS NEW SURVEY AND CERTIFICATION REQUIREMENTS AND ENFORCEMENT MECHANISMS. OUR STAFF HAS BEEN WORKING HARD ON THESE AREAS WHICH I WILL ADDRESS LATER IN MY TESTIMONY.

NURSING HOME REGULATIONS

LET ME ADDRESS THE PROCESS WE ADOPTED FOR DEVELOPING NURSING HOME REFORM REGULATIONS - ONE WHICH IS STILL UNDERWAY. BECAUSE OF THE WIDESPREAD INTEREST IN THESE REGULATIONS, WE CONSCIOUSLY ADOPTED A PROCESS OF CONSULTATION. THIS DECISION MAY HAVE DELAYED ISSUANCE OF REGULATIONS, BUT WE BELIEVE A DELIBERATE AND CAREFUL PROCESS OF CONSULTATION IS ESSENTIAL TO THE SUCCESS OF NURSING HOME REFORM.

OUR REQUIREMENTS FOR LONG-TERM CARE FACILITIES FOCUS ON FACILITY PERFORMANCE AND RESIDENT OUTCOME RATHER THAN ON PROCEDURAL OR PAPERWORK REQUIREMENTS. THE OBJECT OF OUR REGULATION IS TO REQUIRE THAT A FACILITY PROVIDE EACH RESIDENT WITH THE NECESSARY NURSING, MEDICAL AND PSYCHOLOGICAL SERVICES TO MAINTAIN OR ENHANCE THE QUALITY OF CARE FOR EACH RESIDENT. TO HIGHLIGHT ONE IMPORTANT FEATURE - THE RESIDENTS' BILL OF RIGHTS IS INCLUDED IN OUR REGULATION AND ADDRESSES, AMONG OTHER THINGS, THE RESIDENTS' RIGHT TO FREE CHOICE OF A PERSONAL ATTENDING PHYSICIAN AND THE RIGHT TO BE FULLY INFORMED IN ADVANCE ABOUT CARE AND TREATMENT.

ADDITIONAL REQUIREMENTS OF OBRA 87

WE ARE DRAFTING PROPOSED REGULATIONS FOR A NUMBER OF MAJOR OBRA 87 CHANGES THAT MUST BE IMPLEMENTED ON OCTOBER 1, 1990 AND WILL BE PUBLISHED IN THE NEXT SEVERAL MONTHS. THEY INCLUDE -- REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION AND REGISTRY REQUIREMENTS, PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW REQUIREMENTS (PASARR), APPEALS FOR TRANSFER AND

DISCHARGE DECISIONS AND DECISIONS MADE IN THE PASARR PROCESS, STATE NOTICES OF MEDICAID RIGHTS, FEDERAL STANDARDS FOR MONITORING STATE WAIVERS OF NURSE STAFFING REQUIREMENTS, ADMINISTRATOR STANDARDS, AND ITEMS AND SERVICES NOT CHARGEABLE TO PATIENT FUNDS.

DURING THE TIME OF DEVELOPING THESE ADDITIONAL REGULATIONS, HCFA PROVIDES ADVICE TO STATES THROUGH MANUAL INSTRUCTIONS TO GIVE STATES GUIDANCE IN CERTAIN AREAS BEFORE REGULATIONS ARE FINAL. PREADMISSION SCREENING AND THE NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS MANUAL INSTRUCTIONS, FOR EXAMPLE, HAVE ALREADY BEEN ISSUED TO THE STATES.

MANY OF THE OBRA 87 PROVISIONS ARE DIFFICULT TO IMPLEMENT AND COVER EXTREMELY SENSITIVE ISSUES. THERE ARE MANY AND OFTEN COMPETING INTERESTS INVOLVED, FROM NURSING HOME OWNERS TO CONSUMERS AND BOTH THE STATE AND FEDERAL GOVERNMENTS. OUR PRIMARY GOAL IS TO MAKE SURE THAT WE DO WHAT IS BEST FOR THE MEDICARE AND MEDICAID NURSING HOME PATIENT.

ENFORCEMENT

AS THIS COMMITTEE KNOWS, ENFORCEMENT EFFORTS IN THE 1970s FOCUSED ON THE SAFETY OF PHYSICAL PLANT AND SANITATION. THESE CONCERNS WERE RELATIVELY EASY TO TRANSLATE INTO FEDERAL REGULATIONS. IN THE EARLY 1980s, CONGRESSIONAL HEARINGS, RESEARCH AND DISCUSSION CENTERED ON THE REGULATION OF NURSING HOMES. AS I STATED EARLIER, HCFA ISSUED AN NPRM IN THIS AREA IN THE FALL OF 1987.

BECAUSE OF THE MAJOR CHANGES MADE IN OBRA 87, WE DECIDED TO SCRAP THAT REGULATION AND BEGAN DEVELOPMENT OF A COMPLETELY NEW NPRM ON SURVEY, CERTIFICATION AND ENFORCEMENT.

WE ARE CONSULTING WITH AND SHARING DRAFT MATERIAL WITH APPROPRIATE GROUPS. WE ARE PROCEEDING AS QUICKLY AS POSSIBLE WITH OTHER STEPS NEEDED - FOR EXAMPLE, THE MINIMUM DATA SET USED FOR PATIENT ASSESSMENT IS BEING DEVELOPED AND TESTED UNDER CONTRACT.

AS WITH THE NURSING FACILITY REGULATION THAT I DESCRIBED, HERE, TOO, THERE IS A GREAT DEAL OF DISAGREEMENT AMONG INDUSTRY, CONSUMERS AND THE ENFORCEMENT COMMUNITY SURROUNDING THIS AREA. WE RECOGNIZE THAT THIS IS GOING TO HAPPEN AND ARE VIGOROUSLY WORKING TO REACH A CONSENSUS. HCFA HAS MET WITH THE AMERICAN HEALTH CARE ASSOCIATION (AHCA), THE AMERICAN ASSOCIATION OF HOMES

FOR THE AGING (AAHA), THE NATIONAL CITIZENS COALITION FOR NURSING HOME REFORM (NCCNHR), AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP), ASSOCIATION OF HEALTH FACILITY LICENSURE AND CERTIFICATION DIRECTORS, STATE MEDICAID DIRECTORS, CONGRESSIONAL STAFF, AND OTHER INTERESTED GROUPS AND INDIVIDUALS.

I ALSO WANT TO EMPHASIZE THAT ALL REQUIREMENTS FOR CERTIFICATION MUST BE MET BY NURSING FACILITIES. IN THE PAST, WE USED THE CONDITION OF PARTICIPATION FORMAT THAT LED TO SOME MISUNDERSTANDING THAT VIOLATIONS OF LESSER REQUIREMENTS WOULD NOT BE SUBJECT TO FEDERAL ENFORCEMENT. WE WILL NO LONGER USE THE TRADITIONAL "CONDITIONS" AND "STANDARDS" TERMINOLOGY IN OUR REGULATIONS. WE WANT NURSING FACILITIES TO RECOGNIZE THAT ALL OF THE NURSING FACILITY REQUIREMENTS ARE BINDING AND THAT ALL ARE IMPORTANT. AT THE SAME TIME, WE RECOGNIZE THAT VIOLATIONS OF THESE REQUIREMENTS, DEPENDING ON TYPE OR SEVERITY, MAY BE REMEDIED THROUGH THE DIFFERENT ENFORCEMENT MECHANISMS AVAILABLE UNDER STATUTE TO REMEDY THE DIFFERENT KINDS OF VIOLATIONS OF FEDERAL CERTIFICATION REQUIREMENTS.

NURSING HOME INFORMATION RELEASE

AS PART OF OUR OVERALL EFFORT TO IMPROVE THE QUALITY OF NURSING HOME CARE, IN DECEMBER 1988 WE RELEASED DETAILED INFORMATION ON THE POPULATIONS AND PERFORMANCE OF EACH OF THE 15,000 NURSING HOMES THAT PARTICIPATE IN THE MEDICARE AND MEDICAID PROGRAMS. THE PUBLICATION, ENTITLED "MEDICARE/MEDICAID NURSING HOME INFORMATION," CONSISTS OF 75 VOLUMES, WITH AT LEAST ONE VOLUME FOR EACH STATE AND THE DISTRICT OF COLUMBIA.

THE PUBLICATION CONTAINS A PROFILE OF EACH NURSING HOME DERIVED FROM ON-SITE INSPECTIONS. THERE IS ALSO AN OVERVIEW OF EACH STATE'S LICENSING AND ENFORCEMENT PROGRAM, WITH TELEPHONE NUMBERS FOR KEY LOCAL, STATE AND FEDERAL AGENCIES AND ADVOCACY GROUPS. IT REFLECTS CONDITIONS IN THE NURSING HOME AT THE TIME OF ITS MOST RECENT SURVEY AND INCLUDES A SUMMARY OF THE CHARACTERISTICS OF THE RESIDENTS IN EACH HOME, THEIR FUNCTIONAL CAPACITIES AND CARE NEEDS.

THE PROFILES INDICATE WHETHER A FACILITY WAS DEFICIENT AT ITS LAST INSPECTION IN ANY OF THE 32 SELECTED PERFORMANCE INDICATORS USEFUL IN DESCRIBING A HOME'S PERFORMANCE, SUCH AS CLEANLINESS, REHABILITATIVE SERVICES, PROPER NURSING CAPABILITIES AND FOOD QUALITY. THERE IS AN OVERVIEW OF EACH STATE'S LICENSING AND ENFORCEMENT PROGRAM, WITH TELEPHONE NUMBERS FOR KEY LOCAL, STATE AND FEDERAL AGENCIES AND ADVOCACY GROUPS. IN MAKING THE INFORMATION PUBLIC, WE STRESSED THAT PROPER AND RESPONSIBLE USE OF THE INFORMATION DEPENDS ON AN UNDERSTANDING OF THE REPORT'S LIMITATIONS. FOR EXAMPLE, THE DEFICIENCY RATES ARE A "SNAPSHOT" OF CONDITIONS IN THE HOME AT THE TIME THE SURVEY WAS TAKEN. THEY DO NOT DESCRIBE THE SEVERITY OR THE DURATION OF THE PROBLEM OF THE NURSING HOME'S PROMPTNESS IN CORRECTING THE DEFICIENCY. THE REVERSE IS ALSO TRUE: AN INDICATION OF A HOME'S COMPLIANCE AT THE TIME OF THE SURVEY IS NO GUARANTEE THAT THE HOME STILL MEASURES UP TO THE STANDARDS FOR THAT PARTICULAR PERFORMANCE INDICATOR.

HCFA WORKED CLOSELY WITH MANY REPRESENTATIVES OF THE NURSING HOME INDUSTRY, CONSUMER GROUPS, STATE GOVERNMENTS, AND CONGRESSIONAL OFFICES IN DECIDING WHAT INFORMATION TO PRESENT. REPORTS WERE WIDELY DISTRIBUTED TO CONGRESSIONAL OFFICES, STATE SURVEY AGENCIES, PROFESSIONAL ASSOCIATIONS, OMBUDSMAN'S OFFICES, AND MEDICAID AGENCIES.

WE INTEND TO PUBLISH THE NURSING HOME INFORMATION RELEASE ANNUALLY. WE ARE EXAMINING WHAT INFORMATION SHOULD BE ADDED TO OR DELETED FROM LAST YEAR'S RELEASE. AGAIN, WE WILL CONVENE A WORKGROUP MADE UP OF REPRESENTATIVES OF THE MAJOR NURSING HOME, CONSUMER AND STATE ORGANIZATIONS.

OTHER RELATED ISSUES

I WANT TO ADDRESS THE OVERALL IMPROVEMENT IN THE QUALITY OF LIFE FOR THE NATION'S ELDERLY. ADDITIONAL IMPROVEMENTS WERE MADE BY THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 THAT, WHILE NOT DIRECTLY RELATED TO NURSING HOME REFORM, RELATE TO IMPROVEMENT IN THE QUALITY OF LIFE FOR POOR ELDERLY. THERE ARE NEW MEDICAID RECIPIENTS CALLED QUALIFIED MEDICARE BENEFICIARIES (QMBs). THESE INDIVIDUALS ARE MEDICARE PART A ELIGIBLE WITH INCOME UP TO 100 PERCENT OF POVERTY AND RESOURCES UP TO TWO TIMES THE SUPPLEMENTAL SECURITY INCOME LIMIT. THESE POOR ELDERLY WILL HAVE MEDICARE PART A AND PART B PREMIUMS, COINSURANCE AND DEDUCTIBLES COVERED BY MEDICAID.

THE MEDICAID SPOUSAL PROTECTION PROVISION ALLOWS A PERSON IN A NURSING HOME TO TRANSFER SOME INCOME AND/OR ASSETS TO HIS OR HER SPOUSE IN THE COMMUNITY WITHOUT JEOPARDIZING MEDICAID COVERAGE OF THE NURSING HOME CARE. THIS CHANGE IN THE LAW WAS MADE TO BETTER ASSURE THAT THE COMMUNITY SPOUSE HAS ADEQUATE LEVELS OF FINANCIAL SUPPORT.

CONCLUSION

I WOULD LIKE TO CONCLUDE MY STATEMENT BY AFFIRMING OUR COMMITMENT TO THE MEDICARE AND MEDICAID BENEFICIARIES WHO RESIDE IN NURSING HOMES AND WHO LOOK TO US TO PROTECT THEIR RIGHTS AND NEEDS. THIS PROTECTION HAS BEEN OUR FUNDAMENTAL GOAL AS WE HAVE DEVELOPED POLICIES TO IMPLEMENT REFORMS IN NURSING HOME QUALITY. WE HAVE SOUGHT THE MANY, AND OFTEN CONFLICTING, POINTS OF VIEW IN THE DEVELOPMENT OF THE FINAL REGULATIONS; WE CONTINUE TO SEEK ADVICE AS WE DRAFT THE RULES FOR THE OBRA REQUIREMENTS. AS I NOTED EARLIER IN MY STATEMENT, THIS DELIBERATIVE PROCESS IS BY ITS VERY NATURE TIME-CONSUMING. WE CHOSE TO TAKE THAT TIME RATHER THAN TO RUSH THROUGH THE PROCESS SIMPLY TO MEET DEADLINES. TO THOSE WHO CRITICIZE US FOR PROCEEDING TOO QUICKLY WITH PUBLISHING THE FINAL REGULATIONS ON FEBRUARY 2, 1989, I SAY THAT THE NEED TO PROTECT RESIDENTS OF NURSING HOMES IS PRESSING, AND WE SHOULD PROCEED WITH REFORM AS QUICKLY AS POSSIBLE. TO THOSE WHO SAY WE ARE MOVING TOO SLOWLY ON THE OBRA REQUIREMENTS, I SAY THAT WE ARE BEING THOROUGH AND OPEN IN OUR POLICY DEVELOPMENT PROCESS. I BELIEVE WE WILL HAVE A BETTER PRODUCT AS A RESULT. CLEARLY WE HAVE GAINED CONSENSUS IN SOME AREAS; WITH OTHERS WE WILL HAVE TO ACCEPT DIVIDED OPINION AMONG THE INTERESTED PARTIES. BUT, OUR OVERIDING OBJECTIVE AGAINST WHICH WE WILL MEASURE OUR SUCCESS WILL BE THE IMPROVEMENT IN THE QUALITY OF LIFE OF MEDICARE AND MEDICAID BENEFICIARIES WHO RESIDE IN NURSING HOMES.

The CHAIRMAN. Dr. Anthony, thank you for your statement.

I would like to ask a basic question. Would HCFA like for the Congress, in looking at these rules and the August implementation, and in looking at OBRA, to do nothing?

Dr. ANTHONY. Let me say that has been phrased usually here in terms of delaying dates. We are firmly committed to moving forward. I think members of this committee and your staff recognize that the OBRA 1987 legislation was going to press the system forward and it was going to strain it. It was going to strain us at HCFA and, if you inquire of your staff, we told the committee that we frankly would have difficulty meeting the dates in some cases.

The CHAIRMAN. So basically you just didn't obey the law.

Dr. ANTHONY. We did the best that we could and continue to do the best that we can to get this stuff done in a judicious manner. I think you've heard from many people how complex these issues are. I could go through and detail some of the deliberate process, like on the PASARR rules, for instance, and I think you'll see that although we may not have met the due date, in actual fact, had we rushed forward to simply put out regulations that weren't well thought out, it would not have been in anyone's best interest. In fact, the standard against which we all must ultimately be judged—and that is whether or not the quality of care for people in nursing homes would have been improved—I think we wouldn't have violated that.

The CHAIRMAN. We set 10 very specific deadline dates. You failed to meet all of those deadlines. There is not one of those deadlines that you met.

Dr. ANTHONY. I would be glad to go through each one but basically you're right, we have not met most of those deadlines. There are some that, in fact, didn't require regulations which are on your list.

Leaving aside that, it is true that we need to move forward and we're doing it as quickly as possible. I think that if you're at all honest, you would have recognized when the law was passed that we probably couldn't meet a lot of these. As a matter of fact, I guess I'd give one example of something that happened where there was an inconsistency in the due dates between the Medicaid requirements and the Medicare requirements and the catastrophic bill went back to look at that. What Congress did was move the later due date forward, as a matter of fact they moved it to January 1, 1988, for a bill that was passed late in 1987. In fact, we couldn't have met some of these due dates. That doesn't mean that we're not committed to trying to do this as quickly and as judiciously as possible.

The CHAIRMAN. What you've done though, is put out the February 2 rule, in which the States do not know if these rules are going to stand as written, they don't know whether there will be interpretive guidelines, they don't know whether they will be fined or the nursing homes that they regulate will be fined. Don't you see that there is an absolute state of confusion out there created by this?

Dr. ANTHONY. First of all, the February 2 rules are final regulations which will stand. They are final with comment, we may make changes and so forth, and——

The CHAIRMAN. On that point, you brought up a critical point of evidence. Were you in violation of the Administrative Procedures Act?

Dr. ANTHONY. No, sir, we were not.

The CHAIRMAN. Did you give anyone an opportunity to comment on those rules?

Dr. ANTHONY. Yes, sir, we did. There was a publication earlier on of an NPRM that we responded to over 5,500 comments.

The CHAIRMAN. Right. But that was before, not after, OBRA was passed. Is this correct?

Dr. ANTHONY. That is correct.

The CHAIRMAN. Did not you take cognizance of the 1987 OBRA Act?

Dr. ANTHONY. We certainly did. As a matter of fact what we did is the areas which were different in OBRA that we felt ought to be pulled out—and I can give you the example of nurse aide training and the preadmission screening for mentally iil and mentally retarded—we pulled out of those regulations and are going to deal with them in a new NPRM to give people adequate and ample time to comment. On areas that were in our regulation, that OBRA did not address, we felt that we should go forward. There were some areas that OBRA addressed that were in the regulation but you gave us clear direction and we went forward in the way that Congress directed.

I might take a second to tell you what we went forward with that wasn't in OBRA, because I think that's important for you to know. That was the quality of care criteria which asked nursing homes to be sure that patients got proper care—residents could continue to do things like activities of daily living, that residents had their vision and hearing care properly taken care of, they weren't subjected to situations where they'd get bed sores, for instance, that they didn't receive catheters when it became inconvenient for nursing homes to care for them, there's no loss in range of motion, that is a person doesn't lose his ability to move simply because he's not moved around or receiving proper care; we said there should be no accidents, and no dehydration of patients. These are all extremely important things that were included in our February rules that were not in the OBRA legislation and we think it's important to go forward with these things. I would dare say that if the committee had a chance to consider those and voted on them, they would agree.

The CHAIRMAN. I'm going to allow my colleagues the opportunity to question. I have one or two more quick questions.

Why is it that HCFA is saying that they have the enforcement authority and have the authority to set fines and penalties, etc.? Where did you get that authority?

Dr. ANTHONY. The law gives HCFA some authorities, the law gives the States some authorities, particularly in the area of Medicaid, and the law gives the IG some authorities. I think you have heard that there may be some conflicting penalties or enforcement criteria come out of the same survey information. That is, in fact, possible. That's probably something that we all ought to look at more closely to be sure that there is consistency of the decisions and we don't have the State doing one thing or making one re-

quirement based on a survey—I'm talking here of a joint Medicare/Medicaid facility where the State would have the right to make the rules in enforcement decisions under Medicaid and HCFA might have another set under Medicare, and the IG's got another.

The CHAIRMAN. Thank you, Dr. Anthony. I don't know how HCFA interpreted the law this way. I will read from the conference report on the Budget Act: "amends the current Medicare law relating to State"—State—"enforcement of Medicare conditions of participation, requires the State"—State—"to establish and apply the remedies as specified", and so forth. That was the House language, and the Senate and House conferees accepted that language. It is very, very clear to me that the States should have this responsibility. There is in-fighting over at HCFA—even the Inspector General at HHS wants some of this turf. It is an absolute absurdity.

Dr. ANTHONY. My staff has told me and I have looked at these things and——

The CHAIRMAN. Are you a lawyer?

Dr. ANTHONY. I'm not a lawyer, so you've got me there. I assure you that we've got enough to do in HCFA that if somebody else wants to do it, we'd be glad to share the burden.

The CHAIRMAN. That's why we don't understand why you all are fighting for this little piece of turf. I don't know why you want it. The States are out there everyday looking at these facilities. HCFA very seldom goes in there.

Dr. ANTHONY. I would take exception to that. We do have regional offices and we do, in fact, look after the business we're supposed to.

But let's leave that aside. We'd be glad to talk with people who feel the States ought to have all of the enforcement authority. I and my staff would be glad to sit down and talk with people who want to discuss that.

The CHAIRMAN. I'm going to make a plea. I want to let our colleagues ask you some questions or make comments, but I do want to make a plea to you, and this plea is sincere. I want you and your staff to sit down with the staff of the Aging Committee and the individual staffs of these Senators who have been here today. We've had eight members of the U.S. Senate here this morning at this hearing which indicates to me that there is something wrong with what's going on. I don't think anyone would have showed up nor would the hearing have been called had there not been a reason for its existence.

Senator Cohen.

Senator COHEN. Mr. Chairman, I'd like to take exception to the notion that we only show up when there's trouble. [Laughter.]

Dr. ANTHONY. Excuse me, Senator. Could I just comment. I've had placed in front of me the part of the law that refers to the Federal enforcement authority and I just might draw your attention to it, Senator. It is on page 187, section 4203 of the OBRA, which deals with the enforcement process. As I said, I'm not a lawyer but I think there might be more to this story and we ought to look into it in detail.

The CHAIRMAN. We will do that. Thank you, Dr. Anthony.

Senator Cohen.

Senator COHEN. Dr. Anthony, you may not be burdened with a law degree but you are in some cases arguing like a lawyer in that you're pleading in the alternative. On the one hand, you say that when we've been late, we've been deliberative; and when you've been fast, you've been dictatorial. And both are justified under the circumstance. So you seem to be having it both ways. On the one hand, when you've been too fast, you say haste was necessary; when you've been too slow, you're saying we're consulting. I don't think you can have it both ways.

The question I have is, if, in fact, we were not being honest—as you suggested that if we were really honest on this committee, we would have admitted in the setting up of the deadlines that they were unrealistic—if that were the case, why didn't you come in here and ask the committee to delay the implementation or to go back and revise the deadlines. Why didn't you come back and say we can't meet it, we're talking too much to the people in the industry, we're talking to the experts, and we're consulting, and we're trying to make these the best possible regulations? Why just ignore the deadlines and say well, everybody in the committee knew that they were unrealistic and we'll do the best we can and when we finish them they'll all be satisfied? What kind of attitude is that to reflect toward the Administration working with "the rule of law"?

Dr. ANTHONY. First of all, I guess you're right, we've been accused of doing too much, too little, too early, too late. I would say that we have not just ignored the deadlines. If you talk to the staff in HCFA who is doing the work, you will find that they have been working hard. We have not met the deadlines, and you are correct there.

Senator COHEN. Let me give you an example. There remain questions regarding reform of the Ethics in Government Act, the rules pursuant to that legislation and the compliance being insisted upon. Recently, the Bush Administration has come forward saying could you please delay taking action under this particular reform because we haven't been able to resolve some of the problems of personnel. The answer was, of course, we're willing to delay in order to allow for the necessary time.

So the question I have is, When you see there's a deadline that is unrealistic in your judgment and you're making a good-faith effort to comply with that deadline, why not just come to the chairman and the vice chairman of the various committees who have jurisdiction and say we can't meet that deadline, we need more time, we're really acting in good faith, and can you give us a break? It seems to me that's a far more preferable way to proceed in dealing with Congress than simply saying, look, you folks know that we can't measure up here and we'll do the best we can and when we finally get the results, you'll like what we're doing.

Dr. ANTHONY. If that's an invitation, then we'll take you up on it.

Senator COHEN. It's not an invitation. It ought to be automatic.

Dr. ANTHONY. Senator, in general, we do try to do that. Sometimes that is met favorably and sometimes not. I think, as some people have said, the real need here is to set forward a consistent plan and move forward with dates that allow both HCFA, the

States, the nursing homes, everybody involved to have a process with some kind of certainty so that the conclusion in the final analysis meets the objectives. Clearly, we'd like different dates on the ones that we're overdue on. We'd be more than pleased to talk with you or your staff to try to develop such a schedule.

Senator COHEN. But not different dates after the dates have expired. Different dates before they expire.

Dr. ANTHONY. I understand your concern.

Senator COHEN. It's like filing a motion for continuance or a late entry, a late filing——

Dr. ANTHONY. You must be a lawyer.

Senator COHEN. Well, I used to be.

What kind of response did HCFA get on its request for comment on the final regulations that were published on February 2?

Dr. ANTHONY. To my understanding, we've gotten 1,000 comments to date that we will deal with.

Senator COHEN. Deal with in what fashion? What will you do? The regulations are final now, they are effective, what will you do as far as those comments are concerned?

Dr. ANTHONY. The process is that we will deal with comments. By that I mean, we are by law required to deal with all comments, so we will have to publish another regulation that answers the comments and if we find that the comments indicate areas in which we ought to make adjustments and changes, we will take that into consideration and try to make the best decisions possible.

Senator COHEN. In other words, you will treat the comments that you received postpublication of final regulations the same way you would have treated those comments had they come in prior to the final regulations being published?

Dr. ANTHONY. That's correct.

Senator COHEN. Can you tell me whether the February final regulations have as much in common with OBRA as they do with the October 1987 HCFA regulations? Which do they lean toward?

Dr. ANTHONY. Frankly, I can't. We'd have to get a mark-up and we could probably go through that in detail——

Senator COHEN. Do you have a general sense?

Dr. ANTHONY. My sense is that, in general, both OBRA and the HCFA original NPRM had the same core because they stemmed from the recommendations of the Institute of Medicine study. Everything really flowed from that study. There were some significant differences. In the enforcement area, the differences were so significant, as a matter of fact they didn't bear a lot of resemblance to each other, and we entirely scrapped the regulations. My guess is that on the majority of the conditions of participation, the items, in fact, were similar, but on the enforcement, I don't know whether it's 100 percent, but certainly a large fraction in OBRA was different from what we had proceeded with.

Senator COHEN. The term "conditions of participation," have those been dropped from the final regulations?

Dr. ANTHONY. We used to use "conditions of participation" and set out the conditions and the standards. As I indicated in my testimony, there was a lot of concern that standards which weren't as high a criteria as conditions led to some confusion and the fact was that people would not feel they had to meet the same standards

both of compliance and enforcement. So we are dropping that. I'm not sure what the final title will be, but the idea of conditions and standards has been dropped and there will be requirements. Everyone will have to meet all of the requirements and we want to be certain that they are clear that is, in fact, what we will require.

Senator COHEN. Do you think it makes sense to have a temporary delay until there can be some harmonization of the enforcement and the requirements being set forth?

Dr. ANTHONY. In the enforcement regulation? I think it makes sense to set a new due date because we've obviously not met the ones that we have to date. I would say, yes, we ought to look at the dates; yes, we ought to go forward. But let's continue to press ourselves; let's continue to strain the system, not so that it can't react and can't do it fairly, but we should move forward.

Senator COHEN. I don't have a problem with straining the system, I have a problem when you have what seems to be inconsistent guidance coming from HCFA. We had a situation in Maine where HCFA at one point gave approval, then withdrew approval in the Medicaid program and the State is out about $4.5 million now based upon inconsistent guidance coming from HCFA.

Dr. ANTHONY. Is that based on the nursing home regulations or is that another——

Senator COHEN. It's another program, as I understand. But I'm talking about getting some standardization, of letting the homes in the State know what the terms are going to be. There is a lot of confusion out there now and when you say let's press forward, that's fine to say that, but if there is some ambiguity on how we're pressing or what the responsibilities or the penalties are going to be, we've got a problem.

Dr. ANTHONY. Let me be clear, I think we should press forward, but in a responsible way that offers everybody the opportunity to be sure that they comply with the rules and regulations, so that we eliminate the confusion wherever possible, and at the same time, don't hold back the real reforms the nursing home residents need. That's a balancing act. In fact, I think, as you're suggesting, we ought to look at these dates and try to develop the balance that fits the situation.

Senator COHEN. Thank you very much.

The CHAIRMAN. Senator Shelby.

Senator SHELBY. Thank you, Mr. Chairman.

Dr. Anthony, I'm concerned about the lack of guidance, that's been brought out here, given to the States in implementing the pre-admission screening. Can you tell me why there's been such a delay with the regulatory guidance in this area when HCFA has actually decided to implement the comprehensive "conditions of participation" ahead of schedule? This is a real concern to everyone.

Dr. ANTHONY. I think this is one of the very important pieces of the legislation. Let's take a second and go through it because if I look at what my staff has done, I've got to ask the question that you're asking me—what's going on here?

Senator SHELBY. That's a central question.

Dr. ANTHONY. That's a central answer. Let's answer it, let's be fair about it.

One, the February 2 rule, a lot of the work had already been done before OBRA was ever passed. Now OBRA is passed and we have to deal with that and we have to decide whether to go forward with very important things, like quality of care requirements, rights of nursing home patients, which Senator Heinz was referring to earlier on, or whether to drop that as unimportant. We decided, and some would disagree, that we should go forward. But that does not mean that at the same time we were not trying to implement the PASARR requirements.

Let me go through what happened. You passed the law in December 1987, I think it took us about a month to get a printed copy, and it is kind of hard to know what the law is until we have a copy. On April 12 of that year——

Senator SHELBY. So you know how the States feel about some of your stuff now.

Dr. ANTHONY. There is some similarity.

On April 12, the so-called first draft was put together. I think you would agree, this is a complicated program that's not sitting still. We consulted with a large group of people, many of whom are here today, and they said we don't think you're heading down the right path. They said, if you go this way, you're going to cause a lot of confusion and we suggest that you look more at having outcome criteria. So we took their advice, we went back and we rewrote it and the so-called second draft came out in June.

There was another large meeting with people in June to look at that and we got back some comments and guidance. On September 7, a third draft was put together and that draft was more or less a refinement of the second draft and that draft went to our legal attorneys who took about 2½ to 3 months to look at it because they thought it was complicated. Then we put forth the fourth draft, which, frankly, is the final draft, the manual instruction. That was done in April and got published May 12. During all that time, we're trying to consult with people and trying to get some advice and trying to respond to the comments. If we created all these drafts and hadn't been responsive to any comments, that is, if they didn't change at all, that would be kind of astounding and pretty unreasonable, frankly.

During December through April, the person in charge of this particular endeavor, Tom Hoyer, met 17 times to give speeches with major groups. We tried as best we could to talk to the issues and give advice wherever possible. There have been a number of lawsuits brought, the ones that have been decided to date, I understand, have been decided in HCFA's favor in the sense that we don't even have to publish regulations in this area. But the important thing is clarity. You're right, we didn't meet a specific date. But as I look at it and I try to evaluate my staff's work, I think that they did the right thing.

I wish that we had met the due date. I wish we could have done it sooner. But in all honesty and all fairness, as I look at the performance, I think that we've done the best job that we could.

Senator SHELBY. Will the States be accountable, Dr. Anthony, for violating the preadmission screening provisions even though they had no guidelines?

Dr. ANTHONY. The answer is, "yes" because in the law——

Senator SHELBY. They would be accountable even though they didn't have any guidelines?

Dr. ANTHONY. That's what the law says.

Senator SHELBY. The law might need to be changed.

Dr. ANTHONY. That's right. I don't have the authority to do that.

Senator SHELBY. But you do have the authority to publish guidelines interpreting the law.

Dr. ANTHONY. We absolutely do. They have now been published. Just to finish the story, the manual instruction will become the basis for the next regulation that is going to be published this summer so that there will be a chance to have further comment through the regulatory process. Although our attorneys say we don't necessarily have to do that, we feel it is important to do that and we will do so.

Senator SHELBY. Of those 1,000 comments that you have received, were a lot of them concerned about this very reason, the fact that the States might be held accountable for violating preadmission screening provisions even though there were no guidelines from HCFA?

Dr. ANTHONY. In all honesty, I have not seen a summary of the last 1,000 comments.

Senator SHELBY. Do you all read those comments?

Dr. ANTHONY. We certainly do and I could give you some summaries of the earlier——

Senator SHELBY. Who does that?

Dr. ANTHONY. The staff of the Bureau of Eligibility and Reimbursement——

Senator SHELBY. Same people who put all these guidelines together?

Dr. ANTHONY. In actual fact, no. But let me make one point. The States are not accountable to HCFA, they are accountable to the law. If that's not the way you wish the law to read, then I do suggest you change it.

Senator SHELBY. That's always an option up here. If you're really concerned at HCFA about the quality of care that the nursing home residents receive, why has there been such a disregard for the statutory deadlines?

Dr. ANTHONY. We have not disregarded the statutory deadlines; we have not met the statutory deadlines.

Senator SHELBY. When you don't meet them, why don't you meet them?

Dr. ANTHONY. We haven't met them because we've tried to get the work done and we just couldn't get it done in time.

Senator SHELBY. Did OMB guide you in that area a lot?

Dr. ANTHONY. No, it did not.

Senator SHELBY. They haven't had anything to do with this?

Dr. ANTHONY. No, they haven't.

Senator SHELBY. No input, now? You're saying none?

Dr. ANTHONY. Can I tell you where they would have an input? What happens in the process is that we write regulations. Once they're written, they go over to OMB for clearance. As they haven't been published, they haven't had their input. They will have a chance to——

Senator SHELBY. For their clearance or veto, right?

Dr. ANTHONY. They have a chance to clear the documents, yes, sir.

Senator SHELBY. OK.

Mr. Chairman, thank you for your indulgence.

The CHAIRMAN. Senator Shelby, that was a fine line of questioning and I appreciate that.

Dr. Anthony, I'm going to let you off the hook here in just a moment.

Dr. ANTHONY. I'd be glad to stay.

Senator SHELBY. Not completely, are you, Mr. Chairman?

The CHAIRMAN. Not completely, but temporarily. Dr. Anthony is a man whom I would call a liberal constructionist of the law. In other words, he and his staff—I'm going to blame them as well—take those sections of the law that they want to enforce, and they enforce them. They take other sections of the law that they may not be interested in enforcing and they wink and blink and squirm and nod and don't do what the law requires. I think that's a liberal constructionist.

This has been troubling to me. I think it has been troubling to the members of the committee this morning who have been here. HCFA has gotten some praise this morning for consulting with various groups, providers, States, and other entities that are involved in this issue—but despite that, you've gotten 1,000 comments as to your February rule, even after all that consultation. How many of those comments were favorable?

Dr. ANTHONY. My guess is that most of them make suggestions for changes. If that's unfavorable, then my guess is that they're all of that nature.

Senator SHELBY. Mr. Chairman, if you'd yield. He just said a minute ago that he hadn't read any of them.

Dr. ANTHONY. I'm just guessing. In general, we have lots of comments. I personally haven't read this set of comments.

The CHAIRMAN. Did anyone in HCFA read the comments?

Dr. ANTHONY. Yes, they do read them. I eventually see them, too. What happens is the staff takes the comments, tries to put them into categories so that you can respond to them——

The CHAIRMAN. You don't hire consultants to read those things, do you?

Dr. ANTHONY. No, we do not.

The CHAIRMAN. OK. Thank you.

Dr. ANTHONY. In all fairness, we take them very seriously. I do see them and I do look at them, but they have to be processed to a certain stage—I don't get every letter coming to me, for instance, and that's a reasonable process to try to deal with them.

The CHAIRMAN. Let me ask two or three more questions. I want to ask a question that Congressman Waxman wants to know about. Congressman Waxman would like to know when HCFA is going to publish regulations relating to nurse aide training and preadmission screening. What is that date of publication?

Dr. ANTHONY. Those dates would be in the next couple of months, this summer sometime. Both of them are in the same regulation.

The CHAIRMAN. You know, sometimes if I don't impose a deadline on myself, I'll say well, I'll go another month or two months.

Why don't we do this right here: Why don't I just put a date here? You tell me what date you're going to publish and let's see how far from the mark——

Dr. ANTHONY. See what happens? OK. I'm going to do something, I'm going to turn around and ask the people who are going to write it what they think——

The CHAIRMAN. Let's have a goal here.

Dr. ANTHONY. August 1.

The CHAIRMAN. OK, August 1, 1989.

Dr. ANTHONY. Can I point out one thing. The preadmission screening manual instruction, which lays things out in great detail, is already available as a manual instruction. I'd be glad to furnish you with a copy of that.

The CHAIRMAN. Now, will the States have to be complying August 2 with these regulations issued August 1?

Dr. ANTHONY. They have to, as I indicated, comply with the law and I believe the due date for compliance of the law was January 1 of this year. Any of the guidelines that get published, obviously, will be prospectively effective.

The CHAIRMAN. So we're going to say August 1, 1989, we're going to get regulations? Right? I'm going to call up Henry Waxman this afternoon and tell him of that date so we'll both be looking for them.

Dr. ANTHONY. I saw him yesterday morning. I wish he had asked me then.

The CHAIRMAN. I saw him yesterday at noon. I had lunch with him and we talked about that a little bit.

Dr. Anthony, did you consult with the States on your February 2 rulemaking? Did you consult with the States on the budget cycle of the States?

Dr. ANTHONY. Yes. There was a discussion of that among a number of people and we were familiar with and knew about some of the problems that some of the States would have in terms of getting budgets.

The CHAIRMAN. Did you consult, for example, with the State of Arkansas? Our legislature only meets 60 days every 2 years. Some folks want it to meet 2 days every 60 years, but——

[Laughter.]

The CHAIRMAN. At any rate, did you know about our legislature, for example, that they may have to have a special session?

Dr. ANTHONY. I was aware that there are numerous States that are in that particular category. I personally did not consult with Arkansas and I'm not sure if anybody on my staff has.

The CHAIRMAN. On another concern, let me read what you published in your February rule: "We believe there will be little or no increased costs for State certification activities." Then, 60 days later, HCFA comes forward with a new "Long-Term Care Facility Survey Procedures" document which states on the front cover: "These survey procedures assume a 40-percent increase in budgeted surveyor hours effective October 1, 1989." How do you reconcile this?

Dr. ANTHONY. On the first statement that you read, did it have a fiscal year attached to it?

The CHAIRMAN. I don't think so, Dr. Anthony.

Dr. ANTHONY. Some of the reconciliation, and I'm not sure whether I've got the right quotes there, but the end of the fiscal year would not have had a huge impact at the beginning period. Let's be clear, though, the statement that it's going to take longer to do these surveys and it will cost more money, I think that's clearly true.

The CHAIRMAN. I'm stressing this--I guess I have on my old Governor's hat—that States have to have time to work around these new budgetary requirements, Dr. Anthony.

Dr. ANTHONY. That's correct.

The CHAIRMAN. I hope we will take note of that.

Dr. ANTHONY. Some of those—as Iowa was indicated earlier on—have asked for an extension. In 47 cases where some of those have been asked for in that particular program, they've been granted. So we have tried to be sensitive wherever we had the latitude in the law to do so. But if you're saying that States have not had a lot of time to try to go through the legislative processes themselves, I think you're right. I agree with you.

The CHAIRMAN. I have a question not directly related to OBRA. Are you allowing nursing homes to "cash in" as a result of the new Medicare Catastrophic Care Act's expanded SNF benefits by allowing the nursing home to move the patients from facility to facility, or room to room, or section to section? Explain how that's working.

Dr. ANTHONY. I must admit I'm not quite sure I know what you're referring to.

The CHAIRMAN. Because the Medicare Catastrophic Care Act expands the Skilled Nursing Facility benefit, those nursing homes with residents newly eligible for the expanded SNF benefit could get higher reimbursement for these residents if they were, for example, to move them from a Medicaid bed to a Medicare bed. Unfortunately, this often means literally that—moving them from bed to bed, or wing to wing, or even home to home. I am concerned that this is occurring too frequently, and possibly in direct violation of some basic residents' rights.

Dr. ANTHONY. Let me investigate it, because I'm not personally familiar with the situation.

The CHAIRMAN. Are you going to strictly adhere to nursing home bill of rights, the Residents' Bill of Rights?

Dr. ANTHONY. Yes, we are. We feel that's an important part of the regulations and the law, too.

The CHAIRMAN. Finally, just to comment, we've done this now 2½ hours, we've heard from various groups, we've heard from the agency involved in this. Sometimes I feel as if—and maybe we're guilty, too, at this end of the room—that we lose sight of what this is all about. We truly lose sight and forget that it's about improving the quality of care and the quality of life for the 1.5 million residents in America's nursing homes. We're up here arguing about jurisdiction, Inspector General versus the States, and even HCFA itself.

I hope, once again, that you will accept my invitation to informally visit with our staff to see if we can get to the real point of what OBRA was all about, and see if we cannot implement it fairly. We're going to have to examine some changes because I don't think the States and providers can get ready, because I don't

think they know what the rules are. That's the purpose of this hearing, to see if we can't come to grips with some of these problems that have been created.

Dr. ANTHONY. I wholeheartedly endorse what you just said. I think we do need to keep in focus the ultimate goal. To the extent that we can participate in discussions to make this a more rational process, we stand ready to do so any time you wish us to.

The CHAIRMAN. Dr. Anthony, let's make it work.

Dr. ANTHONY. Let's do that.

The CHAIRMAN. Thank you very much.

We're going to call our fourth and final panel: Mary Ousley, Administrator of Kenwood House, Richmond, KY, and American Health Care Association member; and Catherine Price, Executive Director, Church of Christ Homes, Annville, PA, and American Association of Homes for the Aging board member.

We appreciate both of you being here. We appreciate your vast patience in sitting here for 2½ hours. Thank you for coming from a long way to make your statement.

You may proceed.

STATEMENT OF MARY OUSLEY, ADMINISTRATOR, KENWOOD HOUSE, RICHMOND, KY, AMERICAN HEALTH CARE ASSOCIATION MEMBER

Ms. OUSLEY. Mr. Chairman and members of the committee, I am Mary Ousley, administrator of Kenwood House, a 108-bed facility in Richmond, KY. My facility has skilled intermediate and residential care. I am here today also representing the American Health Care Association, which does represent some 9,000 facilities all across the United States.

I would like, Mr. Chairman, to acknowledge your leadership and that of the members of your committee in examining the difficulties that nursing facilities, State agencies, and residents are encountering with implementation of the nursing home reform legislation. I have experienced the problems from three perspectives: First, as a nursing home administrator attempting to operate a facility; second, representing the industry with the Health Care Financing Administration on the policy development and the regulatory implementation of many phases of OBRA; and third, as a State president of a State association working very closely with the State trying to bring our State regulations into conformity with the Federal statute.

I wish to say at the onset as a registered nurse, administrator, and owner of long-term care facilities, I have been a very strong supporter of OBRA and have felt that I was in concert with the majority of provisions and certainly want to endorse fully the Congressional intent to enhance our ability to provide a higher quality of care in nursing homes. However, during the past several months and past year I have on occasion during this initial phase of the implementation of OBRA felt that truly our ability to provide that quality care is going to be compromised by the very law itself, or certainly by the implementation.

We feel that there are four components which must be met if we are to have a successful implementation—first being the timely

and complete regulatory guidance from HCFA based on the statute, appropriate education of all parties affected, mandated improvements in the survey system, and full funding to cover the cost of implementing OBRA. The greatest difficulty certainly today being encountered in nursing homes is the unrealistic time frames that were contained in the statute for the key components, as they are now trying to be implemented. I think this has been the problem, that it is primarily related to HCFA's failure to be able to implement in a timely fashion.

We have talked extensively today about nurse aide training and I won't touch on that again except to say from an administrator and from a State perspective, I am very frightened that my ability to continue to retain nurses aides, hire nurses aides, and to improve their skills is going to be compromised by this lack of guidance. The existing nursing aides are very frightened because they don't know what they're going to have to do. Facilities are trying to train nurses aides to take the competency evaluation and they don't know what the minimum curriculum is going to be.

I think it's being responsible and looking from the perspective of either the consumer, the provider, or the legislators, we should not lose sight of what was the original goal of OBRA—that was to enhance the quality of patient care. I think it is far more important to do it right than it is to do it quickly. For this reason, I think that the time frames should be modified. I speak to the same issue on the February 2 requirements that were published. There simply is not time for appropriate training of surveyors or providers to implement these requirements in a responsible fashion.

Lastly, I would wish to speak to the issue of the funding of OBRA. Our preliminary information appears that the majority of States are doing a very poor job in assessing what the actual cost is going to be and we think we must have very definitive guidelines developed by HCFA so that the full cost of implementing the regulations can be covered or truly we will once again be in confusion and we will compromise our ability to provide the quality patient care.

In conclusion, I would like to thank you for this opportunity and would be happy to answer any questions. I certainly would like to extend the American Health Care Association's commitment to continue to work with Congress and HCFA in the implementation process.

[The prepared statement of Ms. Ousley follows:]

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IMPLEMENTATION OF THE NURSING HOME REFORM PROVISIONS
OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

by

Mary Ousley, R.N.
American Health Care Association

before the

SENATE SPECIAL COMMITTEE ON AGING

Washington, D.C.
May 18, 1989

Mr. Chairman and Members of the Committee, I am Mary Ousley, administrator and owner of Kenwood House, a 108-bed nursing facility located in Richmond, Kentucky. I am here today to represent the views of the American Health Care Association (AHCA), the largest association representing the nation's nursing homes. AHCA's membership exceeds 9,000 long term care facilities which care for about 900,000 chronically ill patients each day.

I would like to acknowledge your leadership, Mr. Chairman, and that of the members of your committee in examining the difficulties that nursing facilities, state agencies and residents are encountering with implementation of nursing home reform legislation enacted by Congress in 1987. I have experienced the problems not only as a nursing home administrator challenged with complying with newly mandated requirements, but also as a representative of the industry involved in several working groups with the Health Care Financing Administration (HCFA) in the law's implementation process. I am also President of the Kentucky Association of Health Care Facilities and have been actively working at the state level to bring Kentucky's nursing home laws into conformity with the federal statute.

In the Omnibus Budget Reconciliation Act of 1987 (OBRA), Congress passed comprehensive new requirements and quality standards for nursing homes. This law represents the most extensive revisions to the Medicaid and Medicare statutory requirements for nursing facilities since their inception.

Through OBRA, Congress mandated that over a three-year period long term care facilities change the way they admit residents, assess residents' care needs, protect residents' rights, provide services, hire nursing assistants, charge for certain services, and staff their nursing shifts, among many other requirements. To ensure compliance with these new requirements, Congress also mandated changes in the way long term care facilities are defined, how they are surveyed, and how they are treated when they do not substantially comply with these regulatory standards. In short, OBRA will change the way long term care services are delivered for decades to come. However, changes will be positive only if OBRA is effectively implemented and adequately funded.

It is important to recognize that the reforms of OBRA did not begin in 1987, but rather represent separate and coordinated efforts which spanned the entire decade. These efforts by the Congress, HCFA, consumer advocates, and providers were directed toward assuring that nursing home residents receive high quality care and that the regulatory system enhance a facility's ability to provide such care. These efforts culminated with the publication of a report in 1986 by the Institute of Medicine (IOM) Committee on Nursing Home Regulation, a report whose recommendations formed the foundation of the OBRA reforms.

The charge to the IOM Committee was to formulate "a basis for adjusting federal (and state) policies and regulations governing the certification of nursing homes so as to make [them]...as appropriate and effective as possible." The study's purpose was also to "recommend changes...to enhance the ability of the regulatory system to assure that nursing home residents receive satisfactory care." These two points are extremely significant as OBRA implementation begins. That is, as we evaluate implementation, we must keep in mind that the goal of OBRA, as an extension of the IOM directives, is <u>quality reform, to be achieved through an effective regulatory system</u>.

AHCA continually measures OBRA implementation against this goal. As we review regulatory proposals or HCFA's agenda for implementation, we ask such questions as: Will the proposal enhance the delivery of services? Will the proposal improve the ability of facilities to render quality of care? Does the plan provide for the protection of residents or prospective residents?

Unfortunately, we have not been able to answer all these questions positively. However, since implementation is approaching the mid-way point, there is still opportunity for change. We appreciate the opportunity you have given us to share our concerns with you and to make recommendations for effective implementation of the Congressional mandate that has the potential to positively affect the lives of 1.5 million residents of the nation's 15,000 nursing homes.

AHCA believes that, at a minimum, three elements are critical to the successful, effective implementation of OBRA:

- Timely and complete regulatory guidance from HCFA,
- Appropriate education of all parties affected, and
- Mandated improvements in the survey process.

The greatest difficulty encountered by nursing home providers relates to unrealistic implementation dates for key OBRA provisions -- a problem that has resulted in failure by HCFA to meet statutory time frames for issuing final regulations. Regulatory guidance for provisions with implementation dates in 1988 or early 1989 -- nurse aide training, prescreening of residents for mental illness or mental retardation, and standards for administrators -- exists only in draft form or as issuances to state manuals, if at all. This lack of guidance, information and coordination is placing a serious burden on facilities and could threaten the well-being of residents. The problem presented by nurse aide training illustrates the point.

Nurse Aide Training

According to OBRA, all new nursing home nurse aides must be trained and tested before providing hands-on care to patients. In addition, nurse aides hired before July 1, 1989, must be evaluated for competency no later than December 31, 1989. To ensure that this requirement is appropriately implemented, HCFA was required to promulgate regulations to give states standards for their nurse aide training and competency evaluation programs by September 1, 1988. By January 1, 1989, states were required to begin approving training and testing programs that meet the new federal requirements.

Yet, it was not until late April 1989, that HCFA issued any instructions to the states. And when instructions were issued, they were in the form of a transmittal to state manuals -- not regulation. Transmittals are neither binding, nor final, and a final regulation is not expected until next year.

Problems resulting from lack of federal regulations on this one provision are being felt nationally:

* States have begun to approve training and competency testing programs or to mandate excessive requirements based on draft -- and often erroneous information;

* Facilities have been forced to begin preparing current nurse aides for competency testing without the benefit of minimum curriculum requirements;

* Aides trained in states whose programs may be "deemed" as meeting the new requirements, but which have not yet received that determination from HCFA, do not yet know if they must take a competency test;

* Competency testing to start on July 1, 1989, is unlikely to begin on schedule since states have just received guidance from HCFA, depriving aides of sufficient preparation time and shortening the six-month period they are provided for testing;

* Requirements for training, testing, and program approval are likely to change again next year, since a notice of proposed rulemaking and writing of the final regulation will occur at a later date; and

* We fear that current nurse aides will be discouraged from continuing in, and new aides from entering the long term care field as a result of the uncertainty created by regulatory delay.

These problems interfere with the goal of mandatory training: to improve the quality of care provided by nurse assistants.

AHCA supports the provisions for nurse aide training and testing. We are concerned, however, that states and facilities will have difficulty in evaluating the large number of existing nurse aides in a timely, cost-effective manner. According to HCFA's draft issuance on this issue, the competency evaluation will include both a written component and a skills demonstration. We feel that grandfathering criteria should be developed for nurse aides currently working in nursing homes -- an approach which has been used in the past to certify other health care workers, the most recent being licensed practical nurses.

Conflicts with New Nursing Facility "Requirements"

AHCA is also concerned that the schedule for implementing other OBRA provisions through new "requirements" published in the February 2, 1989 Federal Register, may have detrimental effects on residents, providers, and surveyors. These new requirements will replace the Medicaid and Medicare "conditions of participation" under which nursing facilities currently operate, as of August 1, 1989. They provide new standards governing residents' rights, quality of life, and quality of care. They also necessitate changes in survey procedures so that surveyors can objectively identify and measure compliance with the regulations. To meet this objective, surveyors must be trained, interpretive guidelines must be redrafted, and providers must be

educated in the new requirements which will govern their operations and delivery of care as of August 1, 1989.

These final rules, published with a 90-day comment period ending on May 3, provide little time to accomplish these extensive preparations. Yet, HCFA is going forward with its plans in spite of the lack of clear regulatory guidance for the OBRA provisions with early implementation dates, insufficient time for surveyor training and provider education, inadequate time to revise survey forms and methodology, and the certain need to revise the requirements again next year. AHCA believes that the current schedule will obfuscate the objectives of quality of care achieved through an effective regulatory system --objectives shared by surveyors, consumer advocates, and providers alike.

In comments to HCFA on the new requirements, AHCA recommended that HCFA postpone implementation until October 1, 1990, the implementation date of major OBRA provisions. This postponement will allow sufficient time to prepare regulatory systems, and to educate surveyors and providers. More importantly, it will prevent the uncertainty and potential harm to residents which will result from implementing too many changes in an unnecessarily constrained time frame.

Prescreening for Mental Illness and Mental Retardation

OBRA's requirement that all nursing home residents and applicants undergo screening for mental illness and mental retardation presents another problem with respect to the timely development of regulations. Under the statute, mentally ill and mentally retarded individuals who have lived in a nursing home fewer than 30 months must be discharged is they need "active treatment" but do not require other nursing home services, even if alternative care is not available.

Although the law became effective January 1, 1989, HCFA has yet to issue any regulations or guidance to either states or facilities for implementing this mandate. Without proper guidance, facilities have been placed in the untenable position

of having to screen prospective residents and to decide on the need for special mental health services, without knowing to what standards they will be held accountable. The result has been delayed or denied access to nursing facility services for prospective residents. The potential exists for even more serious problems in the future.

Therefore, AHCA and the American Association of Homes for the Aging joined together and filed a lawsuit against the Department of Health and Human Services to enjoin the implementation of the preadmission screening requirements. The litigation charges the department with violations of the Federal Administrative Procedures Act, equal protection and due process rights of residents and of individuals seeking nursing facility admission, and facilities' due process rights. Additionally, the lawsuit alleges that the government's ability to deny access to nursing home care for mentally ill or mentally retarded patients who are paying for care themselves, is unconstitutional. Similar lawsuits have been filed in federal court in Texas, Louisiana, Idaho and Nebraska.

We believe that implementation of the prescreening requirement has the potential to jeopardize the health and well-being of nursing home residents needing nursing home care. In many cases, patients who have been subjected to the screening process have been forced to wait weeks -- and even months -- to obtain the results of that screen, unjustifiably delaying their admission into a nursing facility. This has frequently caused hardship for families who have been unable to care for these elderly patients at home.

We are also concerned that HHS has not properly determined if adequate alternative treatment facilities exist for patients who are denied admission to a nursing facility because they failed the second level MR/MI screen. Implicit in the screening program's requirement for active treatment of mental illness or mental retardation is that states have adequate specialized facilities and personnel to properly treat these individuals. OBRA requires the Secretary of HHS to make such a determination. Tragically, the Secretary has not done so, thereby, failing to

assure that states have sufficient mental health hospital beds, psychiatrists, psychiatric nurses and social workers to care for nursing home residents who have been displaced, as well as applicants who have been denied nursing home admission.

Furthermore, we believe that HCFA has incorrectly interpreted Congressional intent of the prescreening rule by requiring that all patients, regardless of their pay status, be subjected to this prescreening process. Government should not intrude into the private decisions made by senior citizens, their families and their physicians as to how they spend their own resources on health care. AHCA urges Congress to enact a technical amendment clarifying that this requirement applies only to Medicaid beneficiaries.

Financing OBRA

To ensure that OBRA has a positive effect on the quality of care and the quality of life for nursing home patients, Congress mandated that states amend their Medicaid plans and reimbursement rates to accommodate the costs of OBRA. However, preliminary attempts by state Medicaid agencies to estimate the cost of various provisions of OBRA, demonstrate that the methodologies being employed are, in many instances, grossly inadequate. Unless very specific guidance is provided by HCFA, we feel that eventual litigation is virtually a certainty in many states. More importantly, however, we are certain that without adequate funding, OBRA will be nothing more than a hollow shell, offering the promise -- not the reality -- of improved quality.

To ensure that the promise of OBRA is fulfilled, it is essential that HCFA spell out exactly how the costs of compliance with OBRA's provisions must be "taken into account" by each state. We appreciate HCFA's comments in the February 2 regulations indicating that states must pay these costs "up front" (as opposed to paying two or three years later through the use of indexed cost reports), but unless HCFA puts significant emphasis on the state plan approval process itself in order to

ensure that legitimate costs are truly "accounted for," it is likely that many state Medicaid programs will not come even close to actually paying for OBRA. In fact, the Kentucky Association of Health Care Facilities has been forced to petition the state to appropriate additional Medicaid funding to reimburse nursing homes for the cost of the new OBRA requirements.

Therefore, we feel that HCFA must amend the published regulations to include specific OBRA costing guidance to the individual states, along with definitive published guidelines indicating exactly what OBRA-related criteria HCFA will use in determining whether or not a state plan amendment can be approved.

Other Provisions

OBRA requires that nursing facilties conduct a comprehensive, standardized assessment of residents within four days of admission to a nursing facility. This assessment of a resident's functional capacity will then be used to devise a comprehensive care plan. The requirement is based on the need for more consistent, reliable data to establish standards of care that are less subjective, and more outcome-oriented.

AHCA supports the concept of resident assessment as the cornerstone of the care planning process. However, for it to be a timely and accurate process, there should be a simplified preliminary assessment accomplished within four days which would facilitate the development of an initial, provisional care plan. A more comprehensive assessment care plan should then be required to be developed within a maximum of 14 days.

Another issue of concern to providers is the creation of an employee abuse registry. Whenever a facility employee is proven to have physically or emotionally abused a patient, or misappropriated a patient's property, that fact must be reported by the investigating agency to the state's abuse registry.

First, let me say that long term care providers support the creation of an abuse registry. If facilities are to protect the safety and property of their patients, an accurate and easily accessible source of data on the work histories of new employees must be made available.

What troubles us is the method by which this provision of OBRA is being implemented. Many states already have in place -- and have had for years -- abuse registries. Rather than restructuring these systems simply to meet new regulatory criteria, we urge that Congress make it clear that adequate, functioning systems be allowed to remain in place.

Additionally, we are concerned with the OBRA requirement to establish federal nursing home administrator standards. Although this regulation was to have been issued last year, HCFA has not met that deadline. As an industry, we favor educational requirements for newly licensed administrators, but we would like to ensure that no single educational approach be mandated to the exclusion of others. There are many ways in which an individual may obtain the necessary skills and experience to become an effective nursing home administrator. We urge that when requirements are finalized, they contain as wide a diversity of educational and experience options as possible -- the only way we can ensure a continuing pool of qualified administrators throughout the nation.

Survey and Enforcement Provisions

Implementation problems are not occurring with all provisions of OBRA. In fact, for provisions with October 1, 1990, implementation dates, we are hopeful that the goal of quality reform will be achieved through an effective regulatory system. One of these areas is enforcement.

While it is too early to predict the final outcome, HCFA's current approach to soliciting input is satisfactory. The potential for positive implementation of enforcement provisions is based on a more realistic time frame provided by Congress and on HCFA's willingness to consider recommendations from providers, consumers, and surveyors.

After several intensive meetings with outside groups, HCFA has prepared draft regulatory language containing the elements of a potentially effective system:

* The goal of enforcement is correction;

* Remedies should be applied at the minimal level which will achieve the desired correction;

* A finding does not necessarily constitute a deficiency;

* Deficiency determinations must consider facility responsibility and response, severity of outcome, and scope of the finding;

* Surveyor accountability for decisionmaking is incorporated into the system; and

* A method of resolving disputes between surveyors and providers must be available.

If these elements are retained, surveyor training is modified, and the regulation is further refined, the outcome portends improvement over our current enforcement system.

In conclusion, I would like to thank the members of this committee for examining the problems that we have encountered with the various nursing home provisions of OBRA. I want to extend the assistance of the American Health Care Association in working with the Congress and HCFA to effectively implement these important recommendations to improve the quality of long term care provided in this nation.

OBRA Implementation Dates

(Dates shown are for both Medicaid and Medicare facilities, unless otherwise specified.)

1. Administrator Standards

March 1, 1988 -	HHS must publish standards for nursing home administrators (Medicaid).
March 1, 1989 -	HHS must develop qualifications for SNF administrators (Medicare).

July 1, 1989 -	States must implement these standards (Medicaid).
January 1, 1990 -	States must implement these SNF standards (Medicare).

2. Costs charged to Patient Funds

July 1, 1988 -	HHS must issue a list of costs that may be charged to the patient.

3. Mental Illness & Mental Retardation Prescreening

October 1, 1988 -	HHS must develop criteria for pre-admission screening of MI and MR patients (Medicaid).
January 1, 1989 -	States must begin MI & MR prescreening (Medicaid).
January 1, 1989 -	Facilities may no longer admit MI or MR patients who do not need that level of care (Medicaid).
April 1, 1989 -	States may develop alternative agreements with HHS for handling MI and MR patients (Medicaid).
April 1, 1990 -	States must begin annual reviews of all MI and MR patients to determine if they are placed appropriately (Medicaid).

4. Nursing

October 1, 1990 -	Facilities must have a licensed nurse on duty 24 hours per day and one full time RN 7 days per week, unless a waiver is granted.

5. Nurse Aide Training

September 1, 1988 -	HHS must establish nurse aide training and evaluation requirements.
January 1, 1989 -	States must approve nurse aide training and competency evaluation programs that meet Federal requirements.
January 1, 1989 -	States must establish a nurse aide registry of those aides who have satisfactorily completed training and/or evaluation.
July 1, 1989 -	Facilities must begin providing for competency evaluations of aides employed prior to this date.
January 1, 1990 -	States must begin reviewing and reapproving nurse aide training programs.
January 1, 1990 -	Competency evaluations of aides employed prior to July 1, 1989, must be completed.
January 1, 1990 -	Facilities must not employ, for more than 4 months, a nurse aide who has not satisfactorily completed required training and competency evaluation program approved by the state.

6. Nursing Waivers

October 1, 1988 -	HHS must develop criteria to monitor waivers for licensed nurses.

7. Payments

April 1, 1990 -	States must submit their amended Medicaid plans to HHS showing how payment adjustments will comply with new statutory requirements.

8. Resident Assessment

January 1, 1989 -	HHS must specify a minimum data set of core elements and guidelines for their use.
April 1, 1990 -	HHS must designate one or more resident assessment instruments which meet specifications.
July 1, 1990 -	States must specify a resident assessment instrument.
October 1, 1990 -	Facilities must begin conducting comprehensive annual assessments of residents admitted after this date.
January 1, 1991 -	Facilities must complete assessments of all residents admitted before October 1, 1990.

9. Resident Rights

April 1, 1988 -	States must develop a notice of resident rights (Medicaid).
July 1, 1988 -	Facilities must provide ombudsmen, physicians, and federal and state representatives immediate access to patients.
October 1, 1988-	HHS must set up appeals guidelines for the involuntary transfer and discharge of patients.
October 1, 1989 -	States must provide appeals procedures for involuntary transfers and discharges (Medicaid).
October 1, 1990 -	Facilities must begin notifying patients of their transfer and discharge rights (Medicare).

10. Standard and Extended Surveys

January 1, 1990 -	HHS must develop and validate protocols for standard and extended surveys.
October 1, 1990 -	State survey and certification requirements go into effect.

AMERICAN HEALTH CARE ASSOCIATION ESTIMATES OF THE COST OF IMPLEMENTING OBRA NURSING HOME PROVISIONS

($ in millions)

	Mature System				Federal Cost Only 1990
	Federal	State	Private	Total	CBO
Aide Training	52.1	42.6	65.8	160.5	55.0
Resident Assessment	21.4	17.5	10.9	49.8	--
Staffing - total°	124.3	71.4	105.1	300.8	1.0
Med Dir°	(4.6)	(3.7)	(5.8)	(14.0)	--
MD visits°	(41.5)	(6.1)	(4.3)	(51.9)	--
social workers°	(0.8)	(0.6)	(0.9)	(2:3)	1.0

-Pharmacy Consultant	9.5	7.1	10.7	27.3	--
Patient Funds	29.9	24.5	37.7	92.0	10.0
Surety Bonds	9.8	8.0	12.2	30.0	--
-Activity Director	1.1	0.9	1.3	3.3	--
Committees	7.5	6.1	9.4	23.0	--
Pre-Admin. Screen	148.9	55.4	15.7	220.0	--
Nurse Registry	13.8	11.2	0.0	25.0	--
Active Treatment	0.0	1,642.5	0.0	1,642.5	--
Survey & Certification*	46.4	5.2	0.0	51.6	40.0

\- In conditions of participation, not in OBRA
* In OBRA but not in conditions of participation
o Accelerated by 18 months so acceleration cost is 1.5 times the number shown

ASSUMPTIONS OF ESTIMATES

Nurse Aide Training	Detailed computer generation assuming 99 hours (75 hours initial training with 100 percent turnover plus 24 hours continuing education).
Resident Assessment	Detailed computer generation.
Staffing Requirements	Detailed computer generation.
Pharmacy Consultant	$200 per month per 100 intermediate care facility (ICF) beds.
Patient Funds	16 hours/month/100 beds @ $30 hour.
Surety Bonds	$2,000 per facility.
Activity Director	$1.00/hour added wage @ 40 hours/week/100 beds.
Committees	Detailed computer generation.
MI/MR Prescreening	1.3 million admits and 0.7 million other residents @ $20 each (cost of operation, normal FFP), 0.6 million (30%) detailed screen @ $300 each (75% FFP).
Abuse Registry	500,000 registrants @ $50 each.
Active Treatment	10 percent of current residents @ $30/day. (No FFP -- all state money.)

The CHAIRMAN. Thank you very much, Ms. Ousley.
Ms. Price.

STATEMENT OF CATHERINE PRICE, EXECUTIVE DIRECTOR, CHURCH OF CHRIST HOMES, ANNVILLE, PA; BOARD MEMBER, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Ms. PRICE. Thank you, Mr. Chairman.

I am pleased to represent the American Association of Homes for the Aging. We are a membership organization that represents about 3,400 community service, housing, nursing care, retirement village providers across the United States. Although I have a written testimony that I would like to give you as a part of the record, I also think that part of what I've heard Mary talk about, part of what the others have talked about prior to this pretty much covers the content of my statement. So, in the hope that I don't embarrass my association or myself, I would simply like to give you our summary version and I would then like to take the time to speak about issues that affect the provider community.

We are really making four recommendations and those recommendations deal with the fact that we think there has to be some modification provisions of OBRA requiring the implementation regardless of whether HCFA has fulfilled its requirement to publish the regulations and guidelines, or at least hold State facilities and facilities within those States harmless on some of those guidelines until we have those guidelines in place.

We would request that HCFA be directed to publish the requirements as a Notice of Proposed Rulemaking, with an opportunity for public comment.

We would request that HCFA be directed to publish its proposed interpretative guidelines as a Notice of Proposed Rulemaking.

Finally, we would ask that HCFA be directed to delay implementation of the new survey certification and enforcement systems until such time as the Administration has published other rules and guidelines required by OBRA.

From a provider point of view, I have some major concerns about what isn't being discussed. I think we're like a hurricane or like a tornado, by the time the winds get there the damage is done. Unfortunately, I think that the residents are the ones who feel the wind. We have a number of people—Pennsylvania doesn't have a lot of people with mental illness or mental retardation in their facilities—circumstances need particular attention. We are also more than a metropolitan area, we are a rural area. There are emotional and family ties that the mentally retarded have, and if there are not alternative services available to them, then they really are removed from the very environment that we're trying to protect. I would think that somehow reasonable people can come to reasonable decisions in helping to give the provision of care that best meets the need of the individual. Consideration has to be given to that.

I do not think as a State or as a country we are prepared with the alternative levels of care for people and we, frankly, are cutting off those services that are available to them.

The nurses aide training program—everybody supports education and training but I don't think anyone has looked at the cost impact. I don't think anyone has looked at the human resource shortage that exists. I would ask us to do that in depth.

Certification is a problem. I'm not sure when we talk about final rules, including the patient Bill of Rights, if we have taken the time to thoroughly understand what we're talking about. Patient Bill of Rights are vital and important to the nursing home resident, but when one talks about such freedoms as restriction from any kind of a restraint, including a bed rail, by August 1 of this year, we have other issues to deal with. I would urge us, therefore, to take enough time to do a good job, not get so pushed that we simply respond in a reactionary manner.

Thank you.

[The prepared statement of Ms. Price follows:]

Statement by

Catherine R. Price
Executive Director
United Church of Christ Homes
Annville, Pennsylvania

on behalf of

The American Association of Homes for the Aging

Mr. Chairman and Members of the Committee, I am Catherine Price, Executive Director of the United Church of Christ Homes in Annville, Pennsylvania. I am pleased to be here today representing the American Association of Homes for the Aging (AAHA). AAHA is a national, nonprofit association representing over 3,400 nonprofit facilities providing health care, housing, continuing care retirement programs, and community services to more than 500,000 older individuals every day. Seventy-five percent of AAHA homes are affiliated with religious organizations while the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups.

In the more than two decades AAHA has been providing testimony to this Committee and others we have stressed the importance of meeting the physical, social, emotional and spiritual needs of residents in a manner which enhances their sense of self-worth and dignity, and allows them to function at their highest levels of independence. We appreciate the opportunity to strongly affirm that belief today as we register some of our members' concerns with regard to implementation of the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA).

As you are aware, AAHA was a very active member of the Campaign for Quality consensus process which followed the publication of the Institute of Medicine report on the Quality of Care in Nursing Homes. AAHA was very proud of the manner in which its members and leadership took the "high road" during that process. When members with that history call us and say that nursing home reform is "out of control" we listen. What we hear is that the implementation of OBRA--with its hoped-for quality of life changes for nursing home residents--is not working.

As we see it, there are two sources of our current difficulties. The first relates to the implementation approach of the Health Care Financing Administration (HCFA); the second concerns certain sections of the law itself.

HCFA'S IMPLEMENTATION OF THE LAW

Turning first to implementation of the law, AAHA believes some of the deadlines set for HCFA were, frankly, unrealistic. For example, the law's requirement that HCFA develop federal criteria for state licensure of nursing home administrators by March 1, 1988, nine weeks after the law was passed, was absolutely impossible to implement, given the unprecedented and complex interjection of federal oversight into a traditional state regulatory area.

Nevertheless, within the context of some unrealistic deadlines and the underestimated difficulty of the tasks involved in implementing the law, we believe HCFA has failed to set its priorities correctly in facilitating the transitions required by OBRA. Not all OBRA requirements have the same weight, and some missed deadlines have presented more problems than others. Our complaint is that HCFA has moved too slowly on several critical issues with statutory deadlines already passed, and has moved too quickly on other issues which do not yet need to be addressed. These choices have resulted in chaos and confusion in the nursing home field. Our initial empathy with the tight deadlines given to HCFA by Congress has evolved into frustration because we do not know how to help our members comply with the law, or even to know, in some cases, what the law is. Several examples, illustrative but not exhaustive, come to mind:

1. Preadmission screening for prospective residents with mental illness or mental retardation. This is one of the most controversial provisions of OBRA at the current time, and in fact, has produced almost universal confusion between and within the states because of the manner of implementation.

Mr. Chairman, we believe that both Congress and the mental health advocates intended that this screening provision assist the mentally ill and retarded obtain access to appropriate services. Unfortunately, the provision, as implemented, is instead delaying access, and possibly denying access, to the only care available for these individuals.

OBRA states that as of January 1, 1989, residents must not be admitted to nursing homes without first being pre-screened for mental illness and/or mental retardation, and a determination made regarding their need for active treatment. This area of the law presents many potential problems for states, providers, and nursing home applicants, and should have been given very high priority by HCFA. Unfortunately, because of the time constraints of OBRA, HCFA chose to first publish criteria in the form of nonbinding issuances to the states.

Although the government did solicit input from many organizations in trying to draft guidelines in this area, what emerged were three drafts of nonbinding MR/MI guidance during 1988. These drafts often vacillated between several definitions of critical terms, such as mental illness and active treatment. A subsequent fourth draft, distributed in 1989, contains yet another definition of these terms. None of these drafts, however, contained information on how states should structure the screening process itself.

The result was that while states were trying to establish their own processes and develop alternative disposition plans for residents needing active treatment, HCFA's shifting definitions changed the nature of the population for which the state was planning.

Another troublesome aspect of MR/MI implementation was that at no time during the draft development period did HCFA make concerted efforts to assess the magnitude of the problem which would be presented by its various approaches. The only consistent portion of the MR/MI implementation has been HCFA's position that states and providers will be financially penalized for incorrect admissions after January 1. Unfortunately, this does not begin to address the physical and emotional penalties to residents whose admission may be denied or delayed pending MR/MI determination, nor to those residents who must be transferred if incorrect admission decisions are made based on these nonbinding criteria.

The extent to which the criteria are actually nonbinding is also open to interpretation. AAHA staff have been repeatedly advised by HCFA officials that the purpose of the issuance is to provide only technical assistance to states, pending completion of a formal rule-making process. These criteria, however, have been incorporated by reference into the recently-published survey and certification standards which state surveyors will use to measure provider performance as of August 1. This effectively gives these criteria all the binding force of law, without benefit of formal rule-ma[illegible].

The January 1 deadline is not the only problem with MR/[illegible] implementation. [illegible]viduals who are already in Medicaid-certified facilities must also be [illegible]reened by April 1, 1990 to determine whether they require nursing facility se vices and active treatment. Residents who do not require nursing facility services but do require active treatment, who have been in the facility at least 30 months may choose to remain in the facility, and the state must provide for active treatment. HCFA has provided little guidance to the states on how to implement this part of the law. Because the provider is ultimately responsible for both the existence and quality of all services given to its residents, AAHA members need to know just how the states will be required to respond to residents with active treatment needs. As an association who has a genuine concern regarding the well-being of the elderly, we are alarmed about possible displacement of large groups of older persons. We question whether a new group of homeless is being created.

2. Nurse Aide Training. On July 1 of this year, facilities must begin competency testing of all nurse aides currently employed in nursing homes in order for those aides to continue working in nursing facilities after January 1, 1990.

HCFA's approach to developing criteria for nurse aide training and competency testing has been similar to that described above for MR/MI. Presently, six weeks from the deadline, states still do not even have final distributed guidance, much less a proposed rule, to help them develop competency testing. The states, again under threat of financial penalties, have moved without HCFA's guidance to develop these programs and begin testing. Furthermore, states have moved independently to formulate training programs for aides hired after January 1, 1990. Regrettably, their reward for taking these initiatives will be that their well-intentioned, experimental programs will likely require extensive revamping when federal regulations are actually published. HCFA has been receptive in the development of the testing and training process to input from outside organizations, but while this may have accounted for some of the time needed to meet this OBRA requirement, several months passed between drafts of the documents on nurse aide training with seemingly little progress.

3. Survey and Certification System. By contrast to the approaches used in the MR/MI and nurse aide training provisions, HCFA has moved with great speed to publish new, final Requirements for Long Term Care Facilities -- the regulations which govern nursing homes' participation in Medicare and Medicaid. These regulations, originally promulgated as a proposed rule two months before OBRA was enacted, were published as a "Final Rule with Comment Period" on February 2, 1989, with an effective date of August 1, 1989. Although they purport to implement OBRA, in fact many of the regulations only reiterate the statutory language of the law.

HCFA apparently assumes that the OBRA provisions are "self-implementing" but this assumption is incorrect. Clearly, many of OBRA's provisions are very complex and will demand further explanation and guidance. In addition, providers and consumers have had no opportunity to comment on how the OBRA provisions should be implemented prior to their inclusion in these final regulations.

We believe that the impact of this insufficient guidance and opportunity to comment will soon create problems. HCFA officials have publicly stated their intention to implement the regulations as scheduled on August 1st — regardless of public response.

As providers, the significance of these skeletal OBRA-related Requirements is that they form the basis for state inspections of nursing facilities as of August 1 of this year. A key component of this process will be the Interpretive Guidelines developed by HCFA which contain the instructions for state surveyors to use in determining compliance with the regulations.

We believe that these guidelines exceed the scope of the law, and in some cases, dramatically change care practices and protocols in facilities. Our concern is that HCFA's public position that these guidelines are not subject to formal rule-making, or publication in any form, will result in changes being effected with no prior notice to providers. As an example, the "Quality of Care" Requirement set forth in the February 2 regulations specifies what outcome should be observed among nursing facility residents. The interpretive guidelines go on to identify the specific nursing practices and protocols which must be present as evidence of the facility's attempts to achieve these desired outcomes. The guidelines make no allowances for alternative practices which may be equally acceptable.

The guidelines which interpret the regulation on unnecessary drugs and on physical restraints present the clearest examples of the problem.

In sections never before included in regulations or interpretative guidelines, HCFA has spelled out specific criteria for what constitutes "excessive dosages," "excessive drug therapy," and other inappropriate drug practices. AAHA agrees that these are issues of considerable and broad-based public debate by physicians, nurses, pharmacists, mental health specialists and others. The interpretative guidelines cut off that debate by unilaterally changing the standards of drug therapy by means of this unpublished document.

Changing what amounts to an almost exclusive physician practice judgment through the nursing home regulatory arena is highly inappropriate. This approach not only fails to tell administrators ahead of time what the new practices are, but requires the facilities to change the way in which physicians practice medicine.

Another area concerns the use of physical restraints. We completely concur with the OBRA provision that physical restraints are not to be used for the convenience of staff or for disciplinary reasons, however, as this provision has been developed through the regulatory process, it has taken on an entirely new form.

In the February 2 regulations HCFA restated the statutory language almost verbatim, with the caveat that a separate regulation would specify how physical restraints were to be used. The draft regulatory language reviewed by our staff sets forth rather specific guidelines for the use of restraints as a treatment mode and in emergencies. HCFA has stated that it plans to publish this regulation as a notice of proposed rule-making later this year.

Its plans to publish a formal rule notwithstanding, HCFA has included a new restraint policy in the Interpretive Guidelines which will go into effect August 1. This policy limits the use of restraints to cases of emergencies, which are narrowly defined. The definition of restraints has been broadly interpreted to include everything from geri-chairs to such protective devices as bedrails, an item which is actually required by some state licensing laws. Since the guidelines will not be published, there will be no notice to providers that this new restraint policy is in effect until after August 1, when surveyors start counting bedrails and assigning deficiencies.

AAHA members understand what HCFA is trying to accomplish, and we agree that there needs to be greater research and efforts towards developing restraint-free methods of helping the frail elderly. In fact, a number of AAHA facilities have been active in the movement to become restraint-free. These facilities, however, acknowledge that it takes from six to nine months for a nursing home to complete the transition to a restraint-free environment. Under the Interpretive Guidelines, even if the facilities had notice of the change in policy, they would be given only a few weeks to accomplish the transition.

In view of some of the dramatic changes which will occur in nursing facility practice patterns, it is AAHA's position that the new survey system, from the Requirements for Participation through the Interpretive Guidelines, needs extensive public input before being implemented.

As a final point here, we want to mention the new enforcement system being planned by HCFA. During several meetings that AAHA staff have had with HCFA to discuss the "conceptual framework" for a new enforcement system, we have protested HCFA's end-of-the-year timetable for publication of this proposed system as unrealistic and out of compliance with OBRA's requirement that the new survey protocols be tested and validated.

We understand that HCFA was required by OBRA to develop alternative sanctions early on. The system under discussion, however, goes far beyond enforcement and completely revamps the entire survey and certification process. Although AAHA has long advocated a better enforcement system, we believe the drastic changes being proposed under this new system must be based on more thorough discussion and additional research.

Our discussions with state licensure directors reinforces our serious concerns about these issues. We are aware that surveyor training on the new Requirements, Interpretive Guidelines, and enforcement system has not yet begun. Furthermore, we are told that the final survey forms and guidelines will not be available to the states until July 1. Needless to say, we are somewhat skeptical that meaningful training of 3,000 surveyors nationwide can be accomplished between July 1 and August 1. Additionally, OBRA specifically requires that state agencies meet with providers, residents and their families to explain the state and federal regulations with which facilities must comply. State surveyors who have not been trained themselves will hardly be in a position to educate providers and their residents and families. It appears to us that what we will have on August 1st is a new and confusing set of regulations and guidelines which neither providers nor surveyors will thoroughly understand but which both must implement to avoid OBRA's sanctions.

It is difficult to imagine how this will improve the quality of life for this nation's elderly nursing home residents. We request that Congress ask HCFA to reorder these priorities. The Requirements should be published as a notice of proposed rule-making, along with the Interpretive Guidelines. Implementation of the new survey and enforcement systems should not proceed until they can do so in a manner which advances the welfare of the residents, the viability of the providers, and the efficacy of the surveyors.

OBRA STATUTORY DIFFICULTIES

A number of provisions of OBRA are causing problems for our members, and we will be returning to Congress early this summer with our suggestions for clarifications of the law. At this time, however, we would like to concentrate on one provision of the law which we believe is creating serious and unintended problems.

We refer to this provision as the "immediate implementation" clause. By this phrase we mean those provisions of OBRA which require states and facilities to implement the law, regardless of whether the Secretary has issued regulations or guidelines.

We understand why Congress believed that provision was necessary in drafting OBRA. It is a source of aggravation to Congress to have its intent thwarted by federal and state regulatory systems which fails to implement the law in a timely fashion.

Looking back to the period in which OBRA was drafted, however, Congress could not have anticipated the kind of confusion which would result as 50 states developed their own implementation schemes, absent meaningful guidelines from the federal government. In addition, it was impossible for Congress to foresee how many of the regulatory strategies of HCFA would change the law without notice to the providers and states. The combination of all the events since December 1987 has made OBRA a runaway train. We believe the totality of today's testimony has given you a sense that the "immediate implementation clause" has not been as effective as Congress had hoped.

In conclusion, Mr. Chairman, we would restate our commitment in creating a system which strives to improve the quality of life for nursing home residents. This is a mission of our not-for-profit members.
We are not asking that OBRA disappear but only that its implementation be thoughtful and rational.

In summary, we have suggested the following actions in our testimony today:

1. Modify provisions of OBRA requiring implementation regardless of whether HCFA has fulfilled its requirements to publish regulations and guidelines, or at least hold states and facilities harmless for failure to implement those provisions for which regulations have not been developed..

2. Direct HCFA to publish the Requirements as a Notice of Proposed Rulemaking, with an opportunity for public comments.

3. Direct HCFA to publish its proposed interpretive guidelines as a Notice of Proposed Rulemaking.

4. Direct HCFA to delay implementation of new survey, certification, and enforcement system until such time as the Administration has published all the other rules and guidelines required by OBRA.

AAHA looks forward to working with this Committee to implement OBRA in a manner that yields the major improvements in the quality of life for nursing home residents we all sought when we supported the bill.

The CHAIRMAN. Very good statements from both of you. I have just one or two quick questions.

Did HCFA, Ms. Price or Ms. Ousley, consult with the organizations that you represent this morning before drafting or publishing the February regulations?

Ms. OUSLEY. Yes, we were consulted with and we did have opportunity to review some of the drafts and did have opportunity to talk to HCFA regarding that. We were disappointed with the publications but we were not surprised. We knew they were coming.

The CHAIRMAN. And did your organization make comments after the regulation was published?

Ms. OUSLEY. Yes.

The CHAIRMAN. You were 1 of the 1,000?

Ms. OUSLEY. Yes. And with several requests for change.

The CHAIRMAN. What about you, Ms. Price?

Ms. PRICE. Yes, we have had that opportunity.

I also felt that there were some unrealistic deadlines for HCFA. Of major concern, with the final regulations that have been published, I think it changes the Nurse Practice Act. I think it may change what we also interpret as the Physician Practice Act. I think we deal with some issues that are police issues in abuse and I guess I have some major concerns about the overview that have been given by HCFA in these decisions.

The CHAIRMAN. You just brought up an interesting point about the bed rail. Tell me about that. Are we disallowing bed rails under any of these regulations?

Ms. PRICE. If you take a look at some of the broad interpretations—and that's where, once again, we're hurting because we do not have interpretive guidelines—if we took a look at some of that and really freed up total resident rights. By August 1, bed rails are a restraint. In my opinion, a bed rail is a form of a restraint. And so without good guidelines we are in a position for major fines and we'll have all kinds of other problems.

The CHAIRMAN. Over two decades ago, almost three, I fell out of a hospital bed a few minutes after major surgery. I wish I had had a bed rail because I had to have the operation done all over again. But I was not aware of this and I was not aware of the possibility of that interpretation. The use of restraints poses very hard questions and is a subject for another hearing.

Are you saying that we should seek a delay of the February Rule or the August 1 implementation?

Ms. OUSLEY. In our comments to HCFA, we did request that they delay the implementation until October 1, 1990, and we feel that date would be appropriate.

The CHAIRMAN. I think that's what the Congress had in mind in the first place. We see that there was another interpretation at HCFA. That is precisely why this hearing was held today—to try to straighten that out so we can proceed with a list of rules, regulations, laws, and guidelines that will ultimately benefit the nursing home residents. That's what it's all about and even though it has taken almost 3 hours, it has been a very constructive hearing. We appreciate your being here, all of the witnesses, many of whom have travelled from a long way, given their time, resources, and effort to making this a very constructive hearing. Thank you.

The hearing is adjourned.

[Whereupon, at 12:50 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

JOHN GLENN, OHIO
BILL BRADLEY, NEW JERSEY
QUENTIN N. BURDICK, NORTH DAKOTA
J. BENNETT JOHNSTON, LOUISIANA
JOHN B. BREAUX, LOUISIANA
RICHARD SHELBY, ALABAMA
HARRY REID, NEVADA
BOB GRAHAM, FLORIDA
HERBERT KOHL, WISCONSIN

JOHN HEINZ, PENNSYLVANIA
WILLIAM S. COHEN, MAINE
LARRY PRESSLER, SOUTH DAKOTA
CHARLES E. GRASSLEY, IOWA
PETE WILSON, CALIFORNIA
PETE V. DOMENICI, NEW MEXICO
ALAN K. SIMPSON, WYOMING
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Item 1

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

The Nursing Home Reform provision of the Omnibus budget Reconciliation Act of 1987 (OBRA 1987) created the legislative basis for the most comprehensive overhaul of nursing home care and government regulation since the enactment of the Medicare and Medicaid programs in the mid-1960s. Implementation of this complex and multi-faceted law presents a tremendous challenge to federal and state governments, nursing home providers, and the public.

Concerns have been raised about the Health Care Financing Administration's (HCFA) role in the implementation of OBRA. It has been the contention of many providers, states, and consumers that HCFA has been remiss in carrying out the law's mandates. To date, HCFA has missed every deadline imposed by OBRA -- with the exception of one, which it exceeded by well over one year. Because OBRA requires states to carry out implementation even in the absence of guidance from the federal government, HCFA's actions have caused a great deal of confusion and frustration.

Highlights of this background analysis are:

* The history of the federal government's role in nursing homes
* The development of the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987
* Problems with the Health Care Financing Administration's implementation of the OBRA reforms
* Overview of HCFA's controversial February 2, 1989 Final Rule on Requirements for Long-Term Care Facilities
* Preadmission screening and annual resident review (PASARR), staffing issues, and survey and certification and enforcement

A HISTORY OF THE DEVELOPMENT OF NURSING HOME STANDARDS

When the Omnibus Budget Reconciliation Act of 1987 was signed into law, it represented a tremendous victory for advocates of nursing home residents. The fundamental nursing home reforms contained within OBRA 1987 were the culmination of over 30 years of efforts to improve the quality of care in our nation's nursing homes. The Federal government first became involved in nursing homes with the passage of the Social Security Act of 1935. The Act established a Federal-State public assistance program for the elderly called Old Age Assistance (OAA). Because those writing this law opposed the use of public poorhouses to care for the poor elderly, those residing in public institutions were ineligible to receive OAA payments. This spawned the growth of nursing homes and other private institutions to care for the elderly. When the first national survey of nursing homes was taken in 1954, there were 9,000 homes classified as skilled nursing or personal care homes with skilled nursing facilities; of these, 86 percent were proprietary, 10 percent were voluntary, and 4 percent were public.

In 1950, amendments to the Social Security Act authorized payments to beneficiaries in public institutions and enabled direct payments to health care providers. This legislation also required that participating states establish programs for licensing nursing homes, but did not specify what the standards or enforcement procedures should be. Over the next 10 years, the amount and sources of payments to nursing homes grew steadily, increasing the level of federal involvement in the delivery of nursing home care. Accordingly, attention was drawn to quality concerns. In 1956, the Commission of Chronic Illness called attention to problems with the quality of care in nursing homes, and the states themselves began to report problems.

A special Senate Subcommittee on Problems of the Aged and Aging was established in 1959 (it became the Special Committee on Aging in 1961). It reported that most nursing homes in the United States were substandard, had poorly trained or untrained staff, and offered few services. The report concluded, however, that "because of the shortage of nursing home beds, many states have not fully enforced the existing regulations [established by the aforementioned 1950 amendments to the Social Security Act].... Many states report that strict enforcement of the regulations would close most of the homes."

The Aging Committee began to hold hearings on nursing home problems in 1963, chaired by Senator Frank Moss. Aging Committee hearings in 1965, coinciding with the advent of the Medicare and Medicaid programs, documented great variations in state nursing home standards and enforcement efforts. Medicare and Medicaid greatly expanded the number of dollars available to nursing homes, and gave the Department of Health, Education and Welfare (HEW) the authority to set standards for homes participating in Medicare or Medicaid. Medicaid paid for skilled nursing services, and Medicare paid for care in an "extended care facilities."

Few nursing homes could meet the standards that ECFs were expected to comply with, and in 1967, amendments by Senator Moss to the Medicaid program authorized HEW to develop standards and regulations to be applied uniformly to the states. These amendments included definitions of skilled nursing facilities (SNFs) and intermediate care facilities (ICFs), and gave HEW the authority to withhold federal funds from those facilities not meeting standards.

Interest in increasing the federal role in the oversight of nursing homes grew in the 1970s. The Senate Aging Committee began a series of hearings in 1969 that lasted until 1973 and resulted in 3,000 pages of testimony. At a 1971 Aging Committee hearing, a HEW official testified that 74 percent of the homes participating in Medicare were certified with deficiencies, and further stated that "reliance on state enforcement machinery has led to widespread nonenforcement of federal standards." Testimony such as this led to a series of reports in 1974 critical of nursing homes in the United States.

In 1970 and 1971, a fire that killed 32 nursing home residents in Ohio and food poisoning that killed 32 residents in Maryland brought this issue to national attention. In 1971, President Nixon announced his eight-point plan to improve regulation of nursing homes. This included the establishment of an Office of Nursing Home Affairs (ONHA) in HEW to coordinate these efforts and to study federal long-term care policies. In 1972, Congress passed a law that mandated full federal funding for state survey and certification activities, redefined ECFs and Medicaid skilled facilities as SNFs, and directed HEW to develop a single set of standards for Medicare and Medicaid ICFs. Final regulations implementing this law were issued in 1974, although not without some controversy and criticism from various sources, including Senator Moss, who believed the regulations were too weak.

In 1978, as a result of President Carter's regulatory reform effort, "Operation Common Sense," HCFA announced plans to revise the SNF conditions of participation and ICF standards. Comments surrounding this effort focused on quality of care issues, as well as the enforcement problems in the survey process. There was discussion about elevating certain requirements to conditions of participation, to make them more enforceable. HCFA also determined that revisions to the certification requirements contained in Subpart S of 42 CFR were necessary. After two years of work, HCFA proposed its new rules in 1980. From the beginning, the intention of this reform effort was to focus on patient care and the result of that care on the individual resident. Among the changes that would have been wrought by the new regulations was a combining of the SNF and ICF requirements in a single set in the CFR. However, by the time all the roadblocks to implementation were removed, it was the end of the Carter Administration. Finally, the only change that occurred was that residents' rights were elevated to a condition of participation by HHS Secretary Patricia Harris.

This action was immediately rescinded by the new Administration. In 1981, HHS initiated efforts to diminish regulatory oversight of the nursing home industry under its Task Force for Regulatory Reform. In 1982, the task force proposed the deletion or revision of many conditions and standards. This was followed by such an outcry of opposition that HHS Secretary Richard Schweiker withdrew the proposal (leaving the 1974 rules in effect) and promised not to "turn back the clock" on nursing home regulation.

A few months later, HHS published proposed revisions to the nursing home survey and certification regulations. Among the changes that these new regulations (which would have modified Subpart S) proposed were recommendations that "deemed status" be given to the Joint Commission on the Accreditation of Hospitals (JCAH), so that JCAH-accredited nursing facilities would be treated as meeting federal survey and certification requirements, and that annual surveys be replaced with a flexible two-year survey cycle. The Senate Aging Committee held a hearing on the implications of this in the summer of 1982.

Congressional response to this was to impose two moratoria totaling ten months in which HHS was prohibited from taking any regulatory action. In the summer of 1983, Congress reached a compromise with HHS whereby HHS agreed to postpone all regulatory changes involving nursing homes and contract with the Institute of Medicine (IoM) of the National Academy of Sciences to conduct a study of federal nursing home law.

In March, 1986, IoM released its report entitled Improving the Quality of Care in Nursing Homes. The report, which represented a consensus of all the various interests involved in nursing home care, called for major restructuring of the Conditions of Participation, including abolishing the regulatory distinction between SNFs and ICFs and replacing it with a single set of requirements based on current SNF rules; creating new conditions on Resident Assessment, Quality of Care, Quality of Life, and Administration; elevating residents' rights to a condition of participation; creating new standards for nurse aide training and discrimination again Medicaid recipients; strengthening social services; and major improvements in the survey and certification process and the enforcement capacity of state and federal governments.

Several members of Congress, including Senators Mitchell and Heinz and Congressmen Waxman and Stark, introduced legislation to implement the IoM report. In the spring and summer of 1987, three Congressional committees held hearings on this legislation: the Senate Finance Committee, and the House Ways and Means Committee and House Energy and Commerce Committee. There was a great deal of public support for the IoM recommendations, and a coalition of organizations representing consumers, providers, health care professionals and others was formed under the rubric of the "Campaign for Quality Care" to develop consensus positions to recommend to Congress and HHS for implementation of the reforms.

HHS also reviewed the IoM report. HCFA Administrator William Roper recommended that HHS adopt the IoM proposals that did not cost any money, rejecting several proposals including increased nurse staffing in ICFs, nurse aide training, and prohibitions against Medicaid discrimination. In October, 1987, HCFA published proposed Conditions of Participation based on the IoM study, followed by proposed regulations to revise survey and certification requirements for nursing homes (Subpart S). These two Notices of Proposed Rulemaking (NPRMs) were HCFA's only response to the IoM study, and were what many believe to be an attempt to send the word to Congress that legislation to reform nursing homes was unnecessary -- that HCFA was willing to do it through the regulatory process. Unfortunately, many of the proposed rules fell short of IoM's recommendations; for example, the October NPRM did not propose increasing registered nurse coverage in ICFs, and the November NPRM restated proposals from the discredited 1982 NPRM, such as two-year survey cycles. These actions encouraged Congress to move to enact nursing home reform through the budget reconciliation process.

On December 22, 1987, the Omnibus Budget Reconciliation Act of 1987 became law (Public Law 100-203). Subsection C of OBRA 1987, entitled "Nursing Home Reform," is the most comprehensive revision of federal nursing home law since the original enactment of the Medicare and Medicaid programs in 1965. OBRA entirely revised new federal requirements for the Conditions of Participation, the survey and certification process, and enforcement. The provisions created new requirements for nursing homes, for state survey and certification agencies, for state Medicaid agencies, and the Federal government. OBRA added nearly 20 pages of new requirements to the Social Security Act, with detailed provisions for:

1. Quality of Life
2. Quality Assessment and Assurance
3. Scope of Services and Activities Under Plan of Care
4. Residents' Assessment
5. Preadmission Screening for Mentally Ill and Mentally Retarded Persons
6. Provision of Services and Activities by Qualified Professionals, including:
   - nursing and specialized rehabilitative services
   - medically-related social services
   - pharmaceutical services
   - dietary services
   - on-going program of activities
   - routine dental services
7. Licensed Nurse Staffing Requirements
8. Training and Competency Evaluation of Nurse Aides
9. Physician Services and Clinical Records
10. Professional Social Work Services Staffing Requirements
11. Residents' Rights, including:
    - freedom of choice
    - freedom from restraints
    - privacy and confidentiality
    - accommodation of needs
    - grievances
    - participation in resident and family councils
    - participation in other activities
    - examination of survey results
    - notice of rights, facility charges, and Medicaid benefits
    - rights of incompetent persons
    - use of psychopharmacologic drugs
    - transfer and discharge rights
    - bed-hold and re-admission rights
    - access and visitation rights
    - equal access to care regardless of source of payment
    - protection of residents' funds
12. Management and Administration
13. Life Safety Code and Licensing
14. Sanitary and Infection Control and Physical Environment

Included in the Medicare Catastrophic Care Act of 1988 (Public Law 100-369), were numerous revisions to OBRA 1987. Although most were technical amendments and changes in effective dates, Congress also addressed HCFA's October, 1987 NPRM. Congress directed HCFA not to weaken certain requirements for nursing homes which had not been addressed in OBRA, but that HCFA proposed to do in the NPRM. For example, while OBRA did not address dietary requirements, language in the MCCA conference report made it clear that the Congress was displeased with any effort to delete a number of specific dietary requirements, including the requirement of specified professional qualifications for dieticians and dietary service supervisors.

PROBLEMS WITH HCFA'S IMPLEMENTATION OF OBRA REQUIREMENTS

Despite the degree of detail in the law, the provisions of OBRA need further elaboraton and interpretation so that surveyors, providers and consumers share a common understanding of what the provisions mean and how they are to be put into practice. OBRA requires HCFA to promulgate new standards of care, called requirements, by October 1, 1990, in a logical sequence, after developing the resident assessment tool, testing and validating the survey instruments, and establishing the enforcement system.

OBRA's timetable is intended to give HCFA ample time to develop new regulations based on the law, seek public input into the developmental process, publish proposed regulations for public comment, issue final regulations, adapt the survey process and interpretive guidelines to the new requirements and allow states adequate start-up time before the new requirements would become effective. Unfortunately, much of the implementation of OBRA to date has not followed that timetable. Deadlines set by OBRA have not been met, which has resulted in a great deal of frustration by those implementing the law at the state and local levels. The following is a brief overview of the more salient issues with the implementation of OBRA.

FEBRUARY 2, 1989:
MEDICARE AND MEDICAID: REQUIREMENTS FOR LONG-TERM CARE FACILITIES
FINAL RULE WITH COMMENT PERIOD

Although HCFA withdrew its proposed regulations on survey and certification (Subpart S), it did not take similar action on the October, 1987 NPRM on conditions of participation. On February 2, 1989, HCFA published final rules on the conditions of participation, which it has renamed Nursing Home Requirements. While these final rules primarily report and analyze comments (of which they received 5,500) submitted by the public in response to the October 1987 NPRM, they also purport to implement statutory requirements that appeared for the first time in federal law in OBRA, which was enacted two months after the proposed rules were published. While most of the requirements are effective August 1, 1989, implementation of the rules whose sole source is OBRA is delayed until October 1, 1990.

HCFA intends to implement the final rules exactly as they were published in the Federal Register. They will be enforced as final rules unless and until they publish another set of rules, which HCFA has made no commitment to do. HCFA did not publish new proposed rules after Congress passed OBRA in December, 1987 and has never published a separate NPRM to implement OBRA's requirements on the Conditions of Participation. Publication of the "final rule with a comment period" in February, 1989, was HCFA's first public statement on OBRA's conditions of participation. HCFA invites public comment now, on rules it designates as final, and intends to implement them as published. Public comment that it will receive on the final rule may or may not be reflected in a later set of final rules. The Gray Panthers have filed suit against DHHS Secretary Sullivan asking a federal judge to declare the final rule illegal on the grounds that it violates federal law.

One of the more fundamental changes the February 2 final rule makes is the change in terminology with regard to requirements. The final rule, instead of the previous classifications of "conditions of participation" and "standards", uses instead Level A and Level B requirements, respectively. Because state and federal enforcement of nursing home requirements has depended on whether a violation was of a condition or a standard (violation of a condition being grounds for the federal government's withdrawing a SNF's Medicare certification), this has enormous implications for both survey and certification and enforcement.

There are a number of problems with the February 2 final rule. Some provisions directly quote or paraphrase provisions of OBRA without giving any further explanation, calling them "self-executing." Many of these provisions are not self-executing, requiring instead some regulatory explanation and clarification. For example, the provisions addressing the preadmission screening and annual resident review (PASARR) of mentally ill and mentally retarded persons (discussed in greater detail below) use the term "mental health" but do not give guidance as to what mental health services nursing facilities are required to provide, or how mental health services are different from active treatment. The final rule also is vague on the nurse aide training that OBRA mandated.

Furthermore, some of the provisions of the new Nursing Home Requirements contradict the explicit language and requirements of OBRA and of MCCA. For example, the final rule contains none of the detail about social services contained in the current rules, Congressional intent to the contrary. The same is true with dietary services.

The final Nursing Home Requirements state in numerous instances that DHHS will publish "Interpretive Guidelines" to explain additional binding and enforceable requirements on facilities. These guidelines will not be published in the Federal Register for public comment, but rather through more informal publications such as issuances through state operations manuals. Examples of areas where interpretive guidelines will be issued include resident participation in the assessment process, and the specification of what resident records must be kept confidential by the facility. Some of these issues that HCFA intends to define through these guidelines are statutory requirements under OBRA (such as resident participation in the assessment).

PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW

The Pre-Admission Screening and Annual Resident Review (PASARR) is intended to assure more appropriate placement and mental health treatment for those mentally ill and mentally retarded persons who are inappropriately channeled into nursing homes (those with Alzheimer's are exempted from PASARR, however). HCFA was required by OBRA to have implementing regulations on the pre-admission screening portion of PASARR by October 1, 1988. However, HCFA's actions notwithstanding, OBRA directed the states to implement pre-admission screening by January 1, 1989 (annual resident review would not be required until April, 1990), whether or not final regulations had been issued. As of this writing, HCFA has released four different draft directives, each different from the one preceding it.

For example, the controversial third draft (released in September, 1988), upon which most states have based their implementation of PASARR, precluded almost anyone with a mental illness or mental retardation from residing in a nursing home, even though OBRA gives long-term residents the option of remaining in the nursing home and receiving active treatment for their mental condition. The fourth draft, released in early May as a state Medicaid manual issuance, would allow nursing homes to admit and retain residents with mental disorders if they need nursing facility services. It also permits states to distinguish between new admissions and readmissions (e.g., someone who had to be hospitalized for a period of time), which should clear up some confusion for the states. Problems had arisen when some current nursing home residents were being detained in the hospital waiting to be screened. However, HCFA has stated that everything is subject to change until published in the Federal Register. Needless to say, this has caused a great deal of consternation among state agencies, nursing homes, and consumers.

The American Association of Homes for the Aging and the American Health Care Association, the two major groups representing the nursing home industry, have filed suit against DHHS Secretary Sullivan seeking to stop implementation of PASARR until final rules are published; to require that DHHS ensure that adequate appeal procedures to protect individual's rights and that states provide adequate adequate alternative placement for mentally ill and mentally retarded persons who are refused admission to nursing homes; and to prohibit screening and annual review of private pay patients.

STAFFING ISSUES

Staffing Waivers: OBRA requires all nursing facilities, by October 1, 1990, to provide 24-hour licensed nursing services, and to employ the services of a registered nurse at least 8 hours per day, 7 days per week. For Medicare SNFs, OBRA includes a waiver of the requirement that an R.N. be on duty over 40 hours per week under specified circumstances. For Medicaid NFs (given that the distinction between Medicaid SNFs and ICFs will be eliminated under OBRA), OBRA permits the waiver of either requirement, although under more stringent circumstances than the Medicare SNF waiver. It is intended to be used only in circumstances in which the facility can demonstrate that it has made a diligent effort to recruit the appropriate personnel, and that the safety and well-being of the residents would not be endangered by a waiver.

The February 2 final rule simply restates the legislative language -- it does not provide any specific interpretation as to the circumstances under which a state should grant a facility a waiver. However, the larger problem in this instance may be in the law itself; there are two separate criteria for granting waivers, and neither the law nor the February 2 Final Rule delineates what waiver a facility certified for Medicare and Medicaid is eligible to apply for.

Nurse Aide Training: One of the more important provisions of OBRA called for mandatory training of all nurses' aides. It prohibits the use of any individual as an aide for more than 4 months unless that individual has completed a training and competency evaluation program approved by the state, and is competent to provide those services. Each nurse aide must receive not less than 75 hours of initial training in various general nursing areas, and pass a competency evaluation program. OBRA distinguishes between aides currently working and those who will be employed in the future. The law requires that as of July 1, 1989, states must provide a competency evaluation program that all aides currently working in nursing facilities must complete by January 1, 1990. New aides must complete the training and evaluation programs. Aides must also receive a program of on-going training.

HCFA was required by OBRA to establish standards for nurse aide training by September 1, 1988, a deadline which it has yet to meet. It has released issuances through the state operations manual, the most recent effective May 12, 1989. These issuances are non-binding, pending the issuance of final regulations. HCFA's final rule simply restates the law with regard to nurse aide training, with no guidance as to how states are to proceed with their training programs. It makes nurse aide training a Level B requirement, although most aging advocacy groups contend that it should be elevated to the higher Level A status. The February 2 final rule also does not define "competency," although it permits aides who have not completed training programs to care for patients even if they have not demonstrated competency. This lack of federal guidance has made it difficult for states to implement the nurse aide training programs.

SURVEY AND CERTIFICATION AND ENFORCEMENT

OBRA prescribes that "standard" and "extended" surveys be conducted based upon a protocol which the Secretary has developed, tested and validated by not later than January 1, 1990. Experience and precedent in the development of survey procedures indicate that changes in survey practice require considerable thought, experimentation, and public review.

After several years of federally-funded state experimentation with models of survey practice, HCFA announced plans in 1985 to change the focus of the survey process to a resident-centered, outcome-oriented approach, through resident interviews and observations of residents' conditions and the care they receive. This was done in response to a court order in Smith vs. Bowen that ruled that HCFA had failed in its duty to assure that Medicaid recipients received quality care. At the court's insistence, the survey process and interpretive guidelines were published in the Federal Register with the presumption that in order to change the system, HCFA would have to republish in the Federal Register as a public forum. After extensive discussion, testing, evaluation, and revision, a new survey system was developed. It was not fully implemented until 1988, and is still in a transition period in many states as surveyors learn to conduct it properly.

HCFA now proposes to implement a new survey system by August 1, 1989 to dovetail with its new nursing home requirements. The first draft of regulatory language was distributed in April, with comments due by early May. While still in its development stages, criticisms of the early draft include its lack of specificity with regard to regulatory requirements pertaining to activities, social services, mental health services, etc. There is also concern that the "conditional certification" of six months that initial participants in Medicare (i.e., new to the program) are permitted to have, even if they have deficiencies (so long as they do not constitute an immediate and serious threat) could nonetheless allow facilities with serious deficiencies into the program.

HCFA's internal staff schedule calls for the completion of the survey protocols and interpretive guidelines for distribution to state agencies by July 1, and immediate application as of August 1. Although the preamble to the February Final Rule says that the new

survey protocols would not significantly increase staff time, state survey agencies are now being told to expect a 40 percent increase in surveyor time, effective October 1, 1989. This budget demand is untimely in the context of states' budgeting processes, and few states will be able to accommodate this increase by October 1.

Consumer advocacy groups have raised the possibility that these new survey procedures may be subject to court challenge, as they may be illegal if not published in the Federal Register in accordance with Smith v. Bowen. The new surveys do not have the force of law that regulations would have. Further, surveyors will be expected to administer the new process with limited training, and with limited time with which to iron out the problems that will inevitably arise, even under the most thoughtful of systems. Surveyors may well be vulnerable to challenge of their actions and findings, which could cause them to be overly cautious on their citings of deficiencies.

With regard to enforcement procedures, a number of concerns have been raised. OBRA prescribes the development of a state enforcement system with strong surveillance capabilities and a range of alternative enforcement mechanisms to utilize to respond to a range of non-compliance on the part of facilities. HCFA has yet to provide any guidance to the states as to how to establish their enforcement capacity or specific enforcement mechanisms. Despite having the authority since January 1, 1988 to impose alternative sanctions itself, the federal government has yet to design or utilize any new alternative sanctions.

The draft proposal now under development focus on how to determine when a problem should be cited as a deficiency. The approach is based on a severity/scope index. The severity index assumes that all requirements that a nursing home must meet are equal in importance. Within the severity index are two scales: the resident outcome scale, and the reaction scale. The higher the score on either scale, the more serious the problem. Both the severity and the the scope, or pervasiveness of the problem are to be considered before a problem (i.e. a compliance issue) is determined to be a deficiency (a finding of sufficient severity as to warrant some type of corrective action). Surveyors are also expected to note if the facility is responsible for the problem, were they aware of it, etc.

This approach has been criticized on a number of counts. Many believe it is too prescriptive, and that the focus should be on developing sanctions, rather than how to determine deficiencies. Others believe that not all requirements should be considered equal in importance, that in fact, some are more important than others.

Another potential problem with is HCFA's determination that the Secretary has enforcement authority over all Medicare-certified homes, including dually-certified homes, leaving only Medicaid-certified facilities subject to the states' authority. HCFA's guidelines also give sole authority to the Inspector General at HHS to impose sanctions over these facilities. Although the language in OBRA for Medicare-certified facilities gives the Secretary enforcement authority, it can be argued that the Secretary in turn has the implicit authority to turn that responsibility to the states. This is one of the more controversial aspects of the draft enforcement language from HCFA, as many contend that HCFA does not have the personnel to necessary to make the appropriate determinations or follow-up. Also, placing the sanction authority with the IG moves that very important authority one more step away from those making the deficiency determinations.

CONCLUSION

Many consumers, providers, and states would contend that the Health Care Financing Administration has not risen to meet the challenge presented by the nursing home reforms in OBRA 1987. It is arguably behind schedule in every area for which is has responsibility to provide leadership and guidance to states in order that they may implement OBRA. Yet HCFA has demonstrated its capacity to produce by its publication of the new Long-Term Care Facility Requirements in February and their fast-track timetable for their enforcement, 14 months ahead of schedule. Their priorities in this matter appear to be contradictory to the intent of Congress, which determined an entirely different set of priorities in OBRA. The Aging Committee's hearing on this issue will likely reveal the causes behind HCFA's recent actions, and will look to ways that the Congress can work with HCFA to accomplish what OBRA clearly sets out to achieve.

Item 2

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May 17, 1989

The Honorable David Pryor
Chairman, Senate Special Committee on Aging
G 41 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Pryor:

The American Psychiatric Association, a medical specialty society representing more than 35,000 psychiatrists nationwide, is pleased that you are holding a hearing on the Federal Government's role in implementing the nursing home reform provisions in the Omnibus Budget Reconciliation Act of 1987. Some provisions within OBRA 87 are ones with which we have problems. For the Committee's consideration, as you examine issues related to nursing home reform, APA would like to share with you our attached comments on the recently published final regulations for Medicare and Medicaid Long term Care Facilties.

Our overriding concern is to make certain that implementation of nursing home reform requirements for preadmission screening and resident review do not inadvertently result in the arbitrary exclusion of patients with mental disorders from nursing homes. Within the comments, APA details a number of concerns we have with the final regulations, particularly as they relate to patients with mental disorders. APA has worked closely with HCFA as the guidelines have been developed and will comment formally once the screening criteria are published in a proposed rule.

It is our hope that your Committee will continue to carefully monitor the implementation of the nursing home provisions, and, in particular, the screening for patients with mental illness and mental retardation to make certain that no inadvertent discrimination results. We believe Congress should again address the issue of nursing home reform, and fund active treatment for those individuals who are found to be inappropriately placed in nursing homes.

Sincerely,

Melvin Sabshin

Melvin Sabshin, M.D.
Medical Director

MS/ess/arn

American
Psychiatric
Association

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Jack W. White, D.B.A.
Deputy Director,
Business Administration

May 3, 1989

Louis Hays
Acting Administrator
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, MD 21207

Attention: BERC-396-FC

Dear Administrator Hays:

The American Psychiatric Association, a medical specialty society representing over 35,000 psychiatrists nationwide, takes this opportunity to submit written comments on the final regulations entitled "Medicare and Medicaid; Requirements for Long Term Care Facilities" published February 2, 1989 in the Federal Register at page 5316. These final regulations incorporate many of the recommendations for nursing home reform contained in the Institute of Medicine's 1986 report on Improving the Quality of Care in Nursing Homes and, as well, significant Medicare and Medicaid statutory changes pursuant to the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), P.L. 100-203.

General Comments

We appreciate the significant contributions that the IOM and Congress have made in addressing nursing home reform and the time, effort and energy expended by HCFA staff in developing implementing regulations and instructions on the many aspects of the care and treatment of individuals in the nursing home setting. The APA has welcomed the many opportunities HCFA has offered us (as it has to other physician, provider and patient organizations) to provide our clinical and policy input at various stages of regulatory and interpretive guideline development. We plan to continue our constructive efforts to assure that nursing home patients receive appropriate treatment services, and particularly services for the diagnosis and effective treatment of mental disorders.

As you are undoubtedly aware, studies have documented that substantial numbers of individuals in nursing homes suffer from a mental disorder. Unfortunately, evidence also indicates that psychiatric problems are frequently undiagnosed or misdiagnosed and left untreated. Clearly, the critical importance of accurately diagnosing and effectively treating this population cannot be overstated.

In the near future, the APA's Task Force on Nursing Homes and the Mentally Ill Elderly will be releasing its report on nursing homes and the elderly. This report, supported in part through a contract with the National Institute of Mental Health, presents in detail the role of the psychiatrist in caring for patients with mental disorders in nursing homes, details current psychiatric care approaches to this population, and offers a series of recommendations to existing problems. Upon completion, the APA would be pleased to send this significant report to you.

Without question, the APA views the OBRA 1987 provisions as reflecting Congressional concern that patients in nursing homes receive appropriate nursing home care for their physical and mental illnesses; that patients are not simply warehoused in nursing homes. Thus, our two dominant concerns with regulatory implementation reflect first, that patients receive appropriate and necessary psychiatric care, and second, statutory and regulatory provisions for screening patients with mental illness or mental retardation do not by this very process exclude such patients as a class from the nursing home setting.

Thus, the APA has a very strong interest in the promulgation and implementation of these final regulations. In our view, the regulations can be revised to better meet both our concerns. Finally, the issue of adequate federal financial support of services provided in nursing homes through Medicaid or other federal programs has not been resolved satisfactorily. Until Congress provides additional support, patient access to care and the quality of that care in the nursing home remains at risk.

Conformance to Statutory Requirements

The final regulations do not accurately represent the Medicaid statute's requirements for the provision of services for those patients suffering from a mental disorder. Section 1919(b)(2) of the Social Security Act states that a nursing facility participating in Medicaid "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care." Further, Section 1919 (b)(4)(i),(ii) requires the nursing facility to provide or arrange for "nursing and related services and specialized rehabilitation services" and "medically-related social services" to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." Subsection (b)(4)(iv) also requires "an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident."

These statutory requirements are clear and significant. These are affirmative obligations nursing homes must meet in order to be in compliance and participate in Medicaid. While we understand that HCFA will be publishing separately proposed regulations on various other aspects of nursing home reform mandated under OBRA 87, our review of these final regulations fails to reveal sufficient regulatory language implementing the above noted statutory provisions.

We would offer the following specific revisions to the regulations to bring them into conformance to statutory requirements for services to residents with diagnoses of mental illness so that the statutory provisions can be appropriately implemented.

Resident rights, codified in section 483.10, should be amended to include a statement that the resident has the right to treatment for all mental and physical conditions identified and in accordance with the resident's comprehensive assessment and plan of care. This elevates the resident's right to treatment as a level A requirement and makes it consistent with section 483.20 that requires comprehensive assessments and section 483.25 quality of care requirements. Since this 483.10 also specifies that a resident may refuse treatment, it should also obviously include the corollary right to receive treatment.

In addition, we request clarification of subsection 483.10 (b)(4) regarding the resident's right to refuse treatment. First, where residents have been adjudged incompetent under State law by a court of competent jurisdiction, as noted in subsection (a)(3), applicable state law oftentimes determines how the right to refuse treatment is carried out. We are appreciative of the effort that was made to discuss in the commentary the variability of state law on the right to refuse treatment issue. However, we question HCFA's ultimate solution to the consistent refusal of all treatment, discharge from the facility (page 5321, third column). One alternative HCFA may wish to incorporate into the regulations or subsequent interpretive instructions is that a petition for a court appointed guardian be considered.

Comprehensive assessments, codified in section 483.20 and specificially subsection (b)(2)(iii) should be amended by adding the phrase physical and mental before functional status, and in (vii) by adding mental and before psychosocial status. Clearly, a comprehensive assessment by definition should include assessment of the mental status of the resident in conformance to section 1919 (b)(2) of the Social Security Act as noted above. Since an assessment must be performed under subsection (b)(4)(iv) promptly after a significant change in the resident's mental or physical condition, it is necessary to have available baseline information on the mental status of the resident.

Specialized rehabilitative services, codified in section 483.45 should also be revised to include in that list psychiatric rehabilitation services. This action would permit conformance to section 1919 (b)(4) of the Social Security Act also noted above. The APA would be interested in working with HCFA to define the range and scope of such services.

Role of Physician

The APA specifically approves the retained requirement under section 483.75 (k) that the nursing facility designate a physician to serve as medical director who is responsible for implementation of resident care policies and the coordination of medical care in the facility. However, we must urge that the regulations section 483. 20 better emphasize the role of the physician in conducting the resident assessment and comprehensive plan of care. Specifically, the psychiatrist's role with regard to the diagnosis, treatment and plan of care for those with mental illness must be recognized both in the regulations and the interpretive guidelines.

Moreover, it is important to understand that the psychiatrist is uniquely trained to treat the patient who requires both pharmacotherapy and psychotherapy, an increasingly frequent therapeutic prescription in an era of advancing understanding of complex biopsychosocial components of mental illness. We know that psychiatric symptoms are frequently non-specific and commonly occur in a variety of physical illnesses. There is also evidence indicating that having a psychiatric diagnosis is associated with a high risk of physical illness. In addition, there are a great many physical illnesses that, upon initial presentation, appear to be mental disorders.

The research literature fully documents mental illness produced by infections, thyroid gland dysfunction, chronic encephalopathy related to heart block, Wilson's disease, carcinoma of the pancreas, hyper-parathyroidism, sub-acute encephalitis, strokes, as well as the psychiatric and neurologic impact of AIDS.

Thus, in the nursing home setting we believe additional changes are necessary to help assure that patients in need of psychiatric care are identified, accurately diagnosed and treated. While section 483.20 emphasizes the importance of the comprehensive nursing home assessment, we remain concerned that mental disorders will go undiagnosed or be misdiagnosed. Accordingly, we recommend that this section be revised (or in the alternative the interpretive guidelines) to require consultation with a psychiatrist in situations where a behavioral disturbance is present or where there is significant cognitive deterioration. For example, a psychiatrist is needed to render a differential diagnosis which would distinguish between a drug side effect, an underlying medical condition or a primary psychiatric disorder such as depression. Such consultation should be a requirement whenever these symptoms present themselves.

Finally, we are concerned in 483.40 about the possibility that the requirement of physician visits (initial and subsequent) could become a ceiling rather than floor. Physician involvement with nursing home patients is of paramount importance.

Pharmacologic Therapy

The APA has some significant concerns regarding both the commentary preceding the regulations section on drugs, 483.25 (1), and the specific language as written. First, the commentary on page 5333 strongly implies that an individual who is on long term antipsychotic medication is almost certainly in need of "active treatment". This is a misperception of the role of antipsychotics in the maintenance treatment of patients with chronic psychiatric illnesses. As in patients with other chronic illnesses, maintenance medications are required and do not constitute "active treatment". We assume the HCFA is not suggesting or implying that nursing home residents who receive insulin for diabetes mellitus, antihypertensives, or digitalis and diuretics for cardiac disease were in active treatment and inappropriate for nursing home care.

Further, we believe the commentary underscores a fundamental misunderstanding of antipsychotic drugs. By decreasing psychotic symptoms, these drugs can actually increase initiative, affect and interest in surroundings. Again, the discussion on page 5335 regarding unnecessary drugs states in part that "drug therapy extinguishes normal affect," when, in fact, such therapy may be essential to restore normal affect!

The language of section 483.25 (l) is an improvement over the earlier proposed condition, including subsection (2)(ii) that originally required residents who use antipsychotic drugs to receive gradual dose reductions, drug holidays, or behavioral programming. This subsection now recognizes that efforts to discontinue antipsychotic drug use may not be therapeutically appropriate for all patients, by including the phrase "unless clinically contraindicated in an effort to discontinue these drugs." We suggest, however, the phraseology "unless clinically contraindicated" sufficient as the remainder is unnecessary and potentially confusing.

Screening Requirements and Active Treatment

The nursing home prescreening requirements for the mentally ill and mentally retarded contained in Section 1919 (b)(3)(F) of the Social Security Act and codified in 483.20 (f) and effective January 1, 1989 remain very troubling to the APA. As stated in our introductory remarks, we continue to be deeply concerned that the required screening could result in the arbitrary exclusion of the mentally ill from the nursing homes on the basis of a diagnosis or an incorrect belief that treatment services provided by nursing homes will be considered "active treatment" and not be reimbursed under Medicaid.

Over the past year, the APA has cooperated with HCFA in the development of interpretive guidelines for the screening criteria. Those guidelines have just been disseminated to the states and will be subject to additional rulemaking. The critical issue of defining "active treatment" for purposes of the nursing home setting, that is where placement may be inappropriate, has hopefully been adequately addressed through the new screening criteria. We urge HCFA to publish proposed regulations on the screening criteria expeditiously to permit review and comment by all interested parties. Certainly the APA plans to comment on that upcoming proposed rule. In the interim, we will continue to monitor the application of the screening criteria by the states and the nursing homes so as to assure that our patients are not denied access and appropriate care. We recommend that HCFA also closely monitor the implementation of these criteria and act swiftly to prevent any discrimination against the mentally ill or the mentally retarded.

Conclusion

In closing, the APA hopes its comments are helpful in the review of these regulations and their republication in final form. As always, we would be pleased to work with HCFA to assure that appropriate standards are promulgated to protect our patients and provide them necessary services.

Sincerely,

Melvin Sabshin

Melvin Sabshin, M.D.
Medical Director

Item 3

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-8400

June 21, 1989

The Honorable Louis W. Sullivan, M.D.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sullivan:

I am writing to follow up on a meeting that members of the Special Committee on Aging staff held on June 14 with staff of the Health Care Financing Administration. The meeting was held to discuss issues related to the implementation of the nursing home reform provisions contained within the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) that were raised at the Aging Committee's May 18 hearing on that subject.

One of the more salient issues that was raised at the hearing and later discussed at the meeting was the delay of the February 2, 1989 Final Rule on Requirements for Long-Term Care Facilities. My purpose in writing to you is to reiterate my view that, at minimum, the February Final Rule should be delayed. As the May 18 hearing clearly demonstrated, the August 1, 1989 date is inappropriate and represents a serious hardship to states, providers, and ultimately, to nursing home residents. There is virtual unanimity on this point. I also wish to express my concern about extending the effective date only to January 1, 1990, as I believe that to be premature. A delay to that date would not meet the objections of the states, providers, or consumers.

I appreciate HCFA's willingness to work with the Committee on this issue, and am pleased to have this opportunity to express my concerns to you regarding it. I look forward to continuing to work with you on this and other issues related to the implementation of OBRA 1987 nursing home reforms, and hope to hear from you at your earliest convenience.

If you have any questions or comments, please do not hesitate to contact me or have your staff contact Mr. William Benson of the Aging Committee staff at 224-5364.

Best regards.

Sincerely,

David Pryor

David Pryor
Chairman

Item 4

John R. McKernan, III
Governor

Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

May 19, 1989

The Honorable William S. Cohen
Unites States Senate
322 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Cohen:

This letter is to follow-up on a conversation between myself and Mr. Adam Understein of your staff concerning the implementation of the Nursing Home Reform Act by the Health Care Financing Administration.

One of the issues I mentioned to Mr. Understein was the sense that the input of the Medicaid agencies was not particularly important. As a point of information, I am the Chair of the Technical Advisory Group of the State Medicaid Directors Association on the Nursing Home Reform Act, and as such have had an opportunity to meet with our advisory group with representatives of the Health Care Financing Administration. The sense is that we are treated as one of many interest groups, not as partners in implementing a major change in the nursing home program. State Medicaid Programs are the key agencies in developing policy, reimbursing for services, carrying out all the administrative tasks responsible for these changes, and we need to be heard in the process of developing Federal regulations and policies.

I am sure you are aware that the Health Care Financing Administration has missed many deadlines for regulations that were to be developed as part of the Nursing Home Reform Act. At the same time the states are held responsible for going ahead and complying with the law which, although the law holds the states harmless in some areas, there is no provision for assuring that penalties are not imposed at some later date. Draft policy and guidance transmittals have been distributed that have conflicted with other transmittals addressing the same issue. Some of the guidance that has been provided appears to be inconsistent with the statute, which causes us great concern. One of the areas that is facing us right now is the competency evaluations of nurses aides that completed training programs prior to January 1, 1989. The policy that has been distributed is inconsistent from one transmittal to another, which creates very real dilemmas at the state level. Another unresolved issue is the Medicare share of nurse aide training and how those funds are to be made available to the states. We have been told to include those costs on a reporting form, but have received no assurance that we will in fact get any of those funds in excess of

of what was approved for our budget for the survey and certification agency.

We are also greatly concerned about the most recent draft of the preadmission screening and annual resident review (PASARR) regulations. Although the statute does not indicate that active treatment cannot be provided in a facility, the interpretation of HCFA is that anybody who requires active treatment cannot remain in the nursing care facility. We feel this is unrealistic and not even in the best interests of elderly nursing home residents. Undoubtedly there are situations when placement in a psychiatric hospital is the most suitable treatment plan. However, there are also many patients who experience moderate to severe depression in a nursing home which could be treated very adequately in that setting. In fact, movement into a psychiatric hospital might further exacerbate the psychiatric problem. We also have a limited number of mentally retarded children in one of our skilled nursing facilities in Maine because of the extensive medically related skilled nursing needs. These children do still need active treatment for their mental retardation, but they also need the level of care provided in the SNF. We would urge that there be some options in dealing with these situations.

The last area that I would like to mention is the policy that is being developed under the enforcement provisions of the Nursing Home Reform Act. What is proposed is to put the enforcement completely under Medicare, even though the Medicaid Program is funding many of the services provided in these same facilities. The law has required that the states develop provisions for sanctions for these facilities, and just because a facility is also Medicare certified, it should not remove all jurisdiction for Medicaid sanctions out of the control of the Medicaid State Agency.

In support of HCFA, I think they were given an incredibly large amount of work to do to implement the Nursing Home Reform Act in unrealistic timeframes. A number of their staff have been very helpful, but they simply do not have the answers to give the states. Because of the statutory deadlines, I do feel HCFA has been put in the position of trying to accomplish something that cannot be done that quickly. However, I really have to wonder why they seem determined to go forward with the change in regulations published in the Federal Register of February 2, 1989 to be effective August 1, when there is in fact no mandate to do that.

I hope these comments are helpful. If there is any further information you may need now or at any future time, please feel free to call me at 207/289-2674. Thank you for the opportunity to have this input.

Sincerely,

Elaine E. Fuller
Director
Bureau of Medical Services

bw

Item 5

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

GRAY PANTHERS ADVOCACY COMMITTEE
c/o Abe Bloom
3313 Harel
Silver Spring, Maryland 20906

ELIZABETH WYCKOFF
Isabella Geriatric Center
515 Audubon Avenue
New York, New York 10040

G. JANET TULLOCH
Washington Home
3720 Upton Street, N.W.
Washington, D.C. 20016

ERCIL SCHWINDT
Seneca District Hospital
Brentwood Drive
Chester, California 96020

NELLIE M. STEWART
Rose Manor Nursing Home
3057 Cleveland Road
Lexington, Kentucky 40516

Plaintiffs,

vs.

LOUIS W. SULLIVAN, M.D.,
Secretary
Department of Health and Human Services,
200 Independence Avenue, S.W.
Washington, D.C. 20201,

TERRY COLEMAN
Acting Administrator
Health Care Financing Administration
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201,

Defendants.

JOHNSON, J. [illegible]

Civil Action No.

89- 0605

MAR - 6 1989

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

I. Preliminary Statement

1. Plaintiffs challenge the federal government's publication of final regulations to implement portions of the nursing home reform law enacted by Congress in December, 1987 and amended in July, 1988. The regulations are inconsistent with explicit requirements of federal law, they fail to carry out the intent of the law, and they were published in final form without any prior opportunity for public comment on proposed regulations.

2. Plaintiffs seek a declaration that the final regulations are unlawful as published and an injunction requiring the Department of Health and Human Services to publish proposed regulations that will fully and accurately implement the nursing home reform amendments passed by Congress.

II. Jurisdiction

3. Jurisdiction is conferred on this Court by 28 U.S.C. §1331, which provides for its jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

III. Plaintiffs

4. The Gray Panthers Advocacy Committee is an affiliate of the Gray Panthers, with members residing in seven States and the District of Columbia. A majority of the Advocacy Committee members receive benefits under the Social Security Act; the Committee's major focus is representing the interests of low-income elderly people. Health issues, especially access to services for low-income, minority, and disabled individuals, are a priority for the Gray Panthers Advocacy Committee and for the Gray Panthers. The Advocacy Committee has appeared as amicus in Medicare cases and commented on nursing home regulations proposed by the Health Care Financing Administration in October, 1987. Advocacy Committee members are potential nursing home residents.

5. Plaintiff Elizabeth Wyckoff has been a resident of the Isabella Geriatric Center in New York since December, 1987. Ms. Wyckoff receives Medical Assistance. Her nursing home participates in the Medicare and Medicaid programs and is subject to the federal regulations at issue in this case.

6. Plaintiff G. Janet Tulloch has been a resident of the Washington Home since 1967. Ms. Tulloh receives Medical Assistance. Her nursing home participates in the Medicare and Medicaid programs and is subject to the federal regulations at issue in this case.

7. Plaintiff Ercil Schwindt has been a resident of the distinct part skilled nursing facility at Seneca District Hospital since May, 1988. Ms. Schwindt receives Medical Assistance. Her nursing home participates in the Medicare and Medicaid programs and is subject to the federal regulations at issue in this case.

8. Plaintiff Nellie M. Stewart is a resident of the Rose Manor Nursing Home. Ms. Stewart receives Medical Assistance. Her nursing home participates in the Medicaid program and is subject to the federal regulations at issue in this case.

IV. Defendants

9. Louis W. Sullivan, M.D., is the Secretary of the Department of Health and Human Services. He is sued in his official capacity.

10. Terry Coleman is the Acting Administrator of the Health Care Financing Administration in the Department of Health and Human Services. He is sued in his official capacity.

V. Federal nursing home law and regulations

11. While all States license nursing homes under State police power, the federal government also sets standards for nursing homes that choose to participate in the Medicare and/or Medicaid programs. Nursing homes that want to be eligible to receive Medicare and/or Medicaid reimbursement must meet these federal requirements, as more fully described below.

12. The Health Care Financing Administration (HCFA) is the part of the Department of Health and Human Services (HHS) that is responsible for administering the Medicare and Medicaid programs at the federal level and for establishing standardsfor nursing homes that participate in one or both federal programs.

13. The Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. §1395, is a health insurance program for aged and disabled people. Part A of Medicare, called the hospital insurance benefits program, pays for care in nursing homes called skilled nursing facilities (SNFs), 42 U.S.C. §1395x(j). The Social Security Act defines an SNF, at 42 U.S.C. §1395, as an

> institution . . . which--
> (1) is primarily engaged in providing to residents--
> (A) skilled nursing care and related services for residents who require medical or nursing care, or
> (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,
> and is not primarily for the care and treatment of mental diseases.

14. The federal regulations governing SNFs that participate in Medicare are called "Conditions of Participation" and appear at 42 C.F.R. Part 405, Subpart K (42 C.F.R.§§405.1101-.1137). Conditions are composed of requirements called Standards, which are in turn composed of requirements called Elements. These regulations define federal nursing home care requirements that SNFs must meet in order to be eligible to receive reimbursement under the Medicare and/or Medicaid programs and address all aspects of care, including, but not limited to, governing body and management, medical direction, physician services, nursing services, dietetic services, specialized rehabilitative services, pharmaceutical services, laboratory and radiologic services, dental services, social services, patient activities, medical records, transfer agreement, physical environment, infection control, disaster preparedness, and utilization review. These regulations are generally unchanged in substance since they were first published in the Federal Register in 1974.

15. Title XIX of the Social Security Act, 42 U.S.C. §1396, authorizes the expenditure of federal funds to enable States to furnish medical assistance to indigent individuals who are aged, blind or disabled, or who are members of families with dependent children. While participation in the Medical Assistance Program ("Medicaid") is optional for States, all States, with the exception of Arizona, participate.

16. The Medicaid program pays for care in two categories of nursing homes: skilled nursing facilities (SNFs) and intermediate care facilities (ICFs).

17. Medicaid's implementation of the SNF level of care explicitly incorporates Medicare's statutory definition, 42 U.S.C. §§1396a(a)(28), 1396d(a)(4), and regulatory requirements, 42 C.F.R. Subpart D (42 C.F.R. §442.200-.202).

18. Medicaid's intermediate level of care is defined by statute, at 42 U.S.C. §1396d(c), as

> an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing homes under State law, and (4) meets the requirements of 1861(j)(14) with respect to protection of patients' personal funds.

19. Federal regulations for ICFs appear at 42 C.F.R. Subparts E and F (42 C.F.R. §§442.250-.346). Like Medicare's SNF regulations, these regulations address all aspects of nursing home care and are substantively unchanged since they were first published in the Federal Register in 1975.

20. While the federal ICF regulations do not use the term "Conditions of Participation," that term is sometimes used as a generic term to refer to the federal regulatory requirements for nursing homes, whether the facilities are designated SNFs or ICFs.

21. The designation of a requirement as a Condition, Standard, or Element has been historically significant in Medicare SNFs because enforcement action has been taken only when Condition-level deficiencies are ide tified and documented.

22. Although participation in Medicare and/or Medicaid is voluntary under federal law for most nursing homes, in fact most facilities in the country currently participate in one or both programs. Participation in Medicare and/or Medicaid is called certification. With limited exceptions, facilities are generally able to choose whatever combinations of certification they wish: they may provide SNF care under both Medicare and Medicaid, or they may provide SNF and ICF care under Medicaid and avoid Medicare entirely, or they may provide only ICF care under Medicaid and avoid Medicare.

23. Once a facility chooses to participate in a federal payment program, it is subject to the federal regulations governing the level of care it is providing.

Most nursing homes in the country are therefore bound by, and required to meet, the federal nursing home regulations promulgated by HCFA. Federal requirements apply to all residents in certified facilities, regardless of the source of payment for their care. As a result, the care of most residents nationwide is governed by federal certification requirements.

24. Since many States also model their licensing requirements on federal Medicare/Medicaid requirements, the federal regulations have a significant effect on all nursing home requirements nationwide.

VI. Factual Allegations

25. Federal efforts to revise the nursing home Conditions of Participation (the term used in its generic sense) have been underway for more than a decade.

26. In 1978, in preparation for drafting new Conditions of Participation, HHS held a series of public hearings across the country to get guidance on what new regulations should include. 43 Federal Register 24,873. (June 8, 1978).

Proposed Conditions of Participation
July, 1980

27. The public hearings culminated in publication of proposed regulations in the Federal Register on July 14, 1980. 45 Federal Register 47,368. These proposed regulations consolidated the two levels of care (SNFs and ICFs), elevated residents' rights to a Condition of Participation, and made other significant changes.

28. In December, 1980, Congress passed Public Law 96-536, §119 of which prohibited HHS from spending any funds to publish, implement, or enforce the proposed regulations on Conditions of Participation until certain conditions were met: January 12, 1981 passed, the General Accounting Office (GAO) issued its report on the cost implications of the proposed regulations, and HHS reviewed and considered the GAO report and revised its cost estimates accordingly for the regulations.

29. On January 19, 1981, HHS Secretary Patricia Roberts Harris signed final regulations on one aspect of the full Conditions: elevating the Standard on Residents' Rights

to a separate Condition of Participation. Secretary Harris' statement on signing the regulations acknowledged that §119 of Public Law 536 prevented publication of the final regulations in the Federal Register because the General Accounting Office had not released its report. Secretary Harris stated that she had spoken with the Comptroller General, who told her his reasons for declining to release the report, but that none of his reasons for non-publication was "factually accurate."

Withdrawal of Secretarial Approval
January, 1981

30. On January 21, 1981, Acting HHS Secretary Donald S. Fredrickson signed a notice for immediate publication in the Federal Register withdrawing approval of the final regulations on Residents' Rights signed two days earlier by Secretary Harris. Acting Secretary Fredrickson's statement said, "I am withdrawing Secretarial approval of the patient rights regulations because the potential impact on both providers and consumers of health care needs to be assesed further."

31. The notice in the Federal Register withdrawing Secretarial approval elaborated on the Department's rationale:

> Because this regulation may have considerable impact on both consumers and providers of health care, we have decided not to issue the regulation, or any portion thereof, until we have had an opportunity to evaluate further all comments received, and the economic impact of the regulation as a whole. For this reason, we have withdrawn Secretarial approval of that section of the regulation approved January 19, 1981.

Federal Register (January 23, 1981).

32. HHS efforts to revise the Conditions of Participation began again. On information and belief, the nursing home Conditions of Participation were among the agenda items for the Vice President's Task Force on Regulatory Relief.

33. A draft version of the Conditions of Participation, which omitted Residents' Rights entirely from federal regulatory requirements and made other significant changes, became public in early 1982. Following a strong negative reaction by members of the public, HHS Secretary Richard S. Schweicker issued a press release on March 21,

1982, in which he "decided against making any changes in current health and safety rules (conditions of participation)" and promised not to "turn back the clock." Secretary Schweicker promised not to eliminate

> . . . any staffing requirements for nursing homes such as medical directors, dietitians, social workers, and other necessary health and safety consultants. In addition, standards for infection control, communicable diseases, and drug administration will not be altered.

The press release also announced that the Department would soon publish "a proposal to improve nursing home inspections."

Proposed Survey and Certification Rules, May, 1982

34. Two months later, on May 27, 1982, HHS published proposed revisions to the nursing home survey and certification regulations. 47 Federal Register 23,403. These regulations, called Subpart S, set out the requirements that States must follow in determining whether a facility is meeting the Conditions of Participation and is eligible for Medicare and/or Medicaid reimbursement. Among the changes proposed in Subpart S were recommendations that "deemed status" be given to the Joint Commission on the Accreditation of Hospitals (JCAH), so that JCAH-accredited facilities would be treated as meeting federal survey and certification requirements; that State agencies verify correction of some violations through telephone calls and correspondence, rather than through mandatory, on-site re-surveys; and that annual surveys be replaced by a flexible, two-year survey cycle.

Congressional Moratoria, 1982

35. In response to a perceived weakening of the enforcement system, Congress enacted two moratoria prohibiting deregulation of nursing homes: one in the Tax Equity and Fiscal Responsibility Act of 1982, Public Law No. 97-248, §135 (signed September 3, 1982), and a second in the continuing budget resolution enacted late in 1982.

36. In the summer of 1983, with the second moratorium about to expire and new moratorium legislation pending (H.R. 2997, 98th Congress, 1st Session (1983)), Congress reached a compromise with HHS in which HHS agreed to postpone all regulatory changes involving nursing homes and to contract with the Institute of Medicine (IOM) of the National Academy of Sciences to conduct a study of federal nursing home law.

Institute of Medicine Report, March, 1986

37. In March, 1986, IOM issued its report entitled Improving the Quality of Care in Nursing Homes. The IOM report called for major restructuring of the Conditions of Participation, including abolishing the regulatory distinction between SNFs and ICFs and replacing it with a single set of Conditions, based on current SNF rules; creating new Conditions on Resident Assessment, Quality of Care, Quality of Life, and Administration; elevating Residents' Rights to a Condition of Participation; creating new Standards under the Condition on Administration on Nurse aide training and discrimination against Medicaid recipients; strengthening requirements on social services; and so forth. The IOM report also proposed major changes in the survey and certification and enforcement processes.

38. Congress responded promptly to the IOM report and Members of Congress introduced a number of bills to implement the IOM's recommendations.

39. HHS reviewed the IOM report as well. A September 5, 1986 memorandum to the HHS Secretary from William L. Roper, M.D., HCFA Administrator, set out HCFA's proposed response to the IOM report and its recommendations. HCFA generally proposed to adopt IOM recommendations that did not cost money. Among the IOM recommendations it rejected were requiring registered nurse coverage in ICFs, requiring pre-service training for nurse aides, and prohibiting facilities from discriminating against Medicaid recipients in admission, transfer and discharge, and covered services.

40. In the Spring and Summer of 1987, the three Congressional Committees with legislative responsibility for the Medicare and Medicaid programs held hearings on proposed nursing home reform legislation based on the IOM's recommendations.

Proposed Conditions of Participation, October, 1987

41. On October 16, 1987, HCFA published proposed Conditions of Participation. 52 Federal Register 38,582. HCFA stated in its preamble that the new requirements are "largely based" on the IOM's recommendations. The proposed rules would have 14 Conditions, including two entirely new Conditions on Quality of Life and Quality of Care, which had

been recommended by IOM. The Notice of Proposed Rulemaking also elevated Residents' Rights to its own Condition, as the July, 1980 proposed rules had done and as IOM had recommended. Other IOM recommendations were omitted from the proposed rule. HCFA did not propose increasing registered nurse coverage in nursing homes, nor did it propose prohibiting facilities from discriminating against Medicaid recipients in admission, transfer and discharge, and covered services.

42. The Congressional Committees marked-up their bills for inclusion in the budget reconciliation act scheduled for passage in late 1987.

43. On November 18, 1987, HCFA published proposed regulations revising survey and certification requirements for nursing homes. 52 Federal Register 44,300. HCFA based some of its proposed rules on IOM's recommendations and, for example, adopted IOM recommendations to consolidate Medicare and Medicaid survey, certification, and adverse action requirements for SNFs and to delete references to surveyors as consultants to nursing homes. However, other provisions in the Notice of Proposed Rulemaking (NPRM) restated proposals from the discredited 1982 NPRM: the 1987 NPRM, like the 1982 NPRM, proposed a two-year survey cycle and deleted the requirement for on-site verification of correction of deficiencies. IOM recommendations not addressed in the proposed rules at all included survey team composition and training and guidelines for the post-survey process, particularly guidance on how surveyors should evaluate plans of correction.

44. The two NPRMs on Conditions and Subpart S were HHS' sole response to the IOM report and recommendations.

Nursing Home Reform Law, December, 1987

45. On December 22, 1987, the Omnibus Budget Reconciliation Act of 1987 (OBRA) became law. Subsection C of Public Law 100-203, entitled Nursing Home Reform, is the most comprehensive revision to federal nursing home law since the original enactment of the Medicare and Medicaid programs in the mid 1960s. Finding HHS' NPRMs to be an insufficient response to IOM and insufficient revision to nursing home law, Congress, in OBRA, entirely revised

federal requirements for the Conditions of Participation, the survey and certification process, and enforcement. The 1987 nursing home reform provisions created new requirements for nursing homes, for State survey and certification agencies, for State Medicaid agencies, and for the Federal Government. Congress changed federal requirements for all private and government agencies involved in institutional long-term care.

46. Many of the IOM recommendations that HCFA had refused to incorporate in its NPRMs on the Conditions of Participation and Subpart S were enacted in OBRA's nursing home reform provisions. For example, with respect to facility requirements, i.e., Conditions of Participation, OBRA consolidated the SNF and ICF levels of care and created a new designation of "nursing facility" under Medicaid, effective October 1, 1990 (Medicare continued its use of the term SNF.); OBRA prohibited nursing homes from using nurse aides who were not competent and trained to do their jobs; and OBRA prohibited facilities from discriminating against Medicaid recipients in admissions, transfer and discharge, and services. With respect to survey and certification, OBRA made the following changes that were not included in HCFA's NPRM on Subpart S: realignment of federal and State responsibilities for survey and certifiction activities; mandating standard and extended surveys; requiring the Secretary to develop, test, and validate survey protocols; requiring surveys to be conducted by interdisciplinary teams of professionals, including a registered professional nurse; prohibiting conflict of interest for survey team members; requiring comprehensive training of State and federal surveyors; requiring the Secretary to conduct on-site validation surveys of a representative sample of facilities, including at least 5% of facilities surveyed by the State, within two months of the States' survey; requiring the Secretary to impose sanctions against State agencies that fail to perform surveys as required; requiring States to maintain procedures and adequate staff to investigate complaints; requiring the Secretary to have specialized survey teams; and requiring the Secretary and States to make available to the public survey and certification information, cost reports, and ownership information.

Nursing home reform amendments, July, 1988

47. On July 1, 1988, the Medicare Catastrophic Coverage Act of 1988 (MCCA), Public Law 100-360, became law and the process of nursing home reform continued. Included in the law were numerous revisions to OBRA's nursing home reform amendments. While most of the revisions were technical amendments (such as removal of an unintended double negative) and changes in effective dates of various OBRA nursing home reform provisions, Congress also addressed the Notice of Proposed Rulemaking that HCFA had published in October, 1987: Congress specifically directed HCFA not to weaken certain requirements for nursing homes, which Congress had not addressed in OBRA, as HCFA proposed to do in the NPRM. For example, while OBRA required facilities with 120 beds or more to employ at least one social worker, Congress did not intend by this new requirement to repeal other current regulatory requirements involving social services. Congress made this intention plain in the conference report on the Catastrophic bill:

> With regard to requirements for social workers included in the OBRA 87 amendments, the conferees intend that the Secretary ensure that requirements regarding consultation and supervision of social work services be at least as stringent as those in effect prior to enactment of the OBRA changes.
>
> * * *
>
> The conferees wish to clarify the requirements in sections 4201 and 4211 of P.L. 100-203 that nursing facilities with more than 120 beds must have a least one social worker (with at least a bachelor's degree in social work or similar professional qualification) employed full-time to provide or assure the provision of social services. Facilities could meet this requirement by employing either a person with a degree in social work or with similar professional qualifications, such as a degree in a related field and previous supervised experience in meeting individual psycho-social needs. It is the intent of the conferees that the Secretary ensure that requirements regarding consultation and supervision of social work services be at least as stringent as those in effect prior to enactment of these changes.

Congressional Record H3840 (June 1, 1988). Congress made clear, by this language, that it did not approve of the changes to social services that were proposed by the Department in the proposed rules published in October, 1987. Similarly, while OBRA contained no new language or direction on dietary services, Congress included the following language in the Catastrophic bill's conference report:

> The conferees also wish to clarify that it was the intent of sections 4201 and 4211 of P.L. 100-203 that the Secretary ensure that the requirements for dietary services be at least as stringent as those in effect prior to enactment of P.L. 100-203.

Congressional Record, H3840 (June 1, 1988). This language once again reflected Congressional dissatisfaction with the NPRM's proposed deletion of a number of specific requirements in the current dietary Condition of Participation, including, for example, the requirement of specified professional qualifications for dietitian and dietary service supervisor. 42 C.F.R. §405.1101(e), (f). In MCCA, Congress directed HCFA to reinstate current regulatory requirements in the new Conditions of Participation it would draft.

48. OBRA's various provisions, as modified by MCCA, become effective at different dates over a period of several years.

49. OBRA's new requirements for facilities (with limited exceptions for such issues as preadmission screening for persons with mental illness or mental retardation) become effective October 1, 1990, the date that consolidation of the two levels of care (SNF and ICF) under Medicaid becomes effective.

50. In recognition of the substantial changes made by OBRA to the survey and certification and enforcement processes, HCFA withdrew its proposed rules on Subpart S.

Final rule on nursing home requirements, February, 1989

51. HCFA has not taken similar action with respect to the Conditions of Participation, despite the comprehensive revision of federal law that occurred through OBRA. On February 2, 1989, HCFA published final rules on the Conditions of Participation, which it now renamed Nursing Home Requirements. 54 Federal Register 5316. While these final rules primarily report and analyze comments submitted by the public in response to the October, 1987 NPRM, they also purport to implement statutory requirements that appeared for the first time in federal law in OBRA, which was enacted in December, 1987, two months after the NPRM was published.

52. HCFA designates these rules "final rules with a comment period" and delays the effective date. While the effective date is generally delayed until August 1, 1989, rules whose sole source is OBRA are delayed until October 1, 1990, the effective date specified in OBRA for consolidation of the two levels of care (SNF and ICF) under Medicaid.

53. HCFA submitted the final Conditions of Participation, now Nursing Home Requirements, to the Office of Management and Budget (OMB) for review under the Federal Paperwork Reduction Act, 44 U.S. Code Chapter 35, before publishing them as final rules in the Federal Register. On information and belief, HCFA published the rules as final rules with comment period after OMB's approval was received.

54. HCFA intends to implement the final rules, exactly as they were published in the Federal Register on February 2, 1989, on August 1, 1989. These rules will be enforced as final rules unless and until the Department publishes another set of final rules.

55. The Department has made no commitment to publish another set of final rules reflecting public comments that are submitted in response to the February 2, 1989 final rules. The Department has said that it will publish new final rules only "if this proves necessary." Letter from Otis R. Bowen to Elma Holder, National Citizens Coalition for Nursing Home Reform, January 12, 1989.

56. If the Department chooses to publish another set of final rules that address nursing home requirements, public comments on the final rules published in the Federal Register on February 2, 1989 may be reflected in that later set of final rules. The Department does not intend to publish another set of final rules before the latter part of 1989, at the very earliest.

57. HCFA did not publish new proposed rules after Congress passed OBRA in December, 1987 and has never published a separate Notice of Proposed Rulemaking to implement OBRA's requirements on the Conditions of Participation. Publication of the final rules on February 2, 1989 is HCFA's first public statement on what requirements OBRA obligates facilities to meet. HCFA refused to solicit or receive any comments on the Conditions

of Participation after the public comment period on the October, 1987 NPRM closed in January, 1988, and, as a result, there has never been any formal and official public comment period on HCFA's interpretation of OBRA's nursing home requirements. HCFA invites public comment now, for the first time, on rules it designates as "final." HCFA intends to implement these regulations as published and without regard to any public comments it may receive, on August 1, 1989.

58. The final Conditions of Participation, now Nursing Home Requirements, contradict the explicit language and requirements of OBRA and of MCCA in a number of respects, including, but not limited to, the following:

a. Social Services: Although Congress, in MCCA, prohibited HCFA from reducing requirements for social services in the Conditions of Participation, the final regulations contain none of the detail about social services that is contained in the current rules. The final rules say that facilities with 120 beds or more must employ a full-time social worker and describe qualifications of social workers. §483.15(g). Current rules, which Congress directed HCFA to retain and which HCFA nevertheless omitted, also define social service functions, staffing, and records and confidentiality of social data, 42 C.F.R. §405.1130 (skilled nursing facilities). Current regulations for intermediate care facilities are similar. §442.344.

b. Dietary services: As with Social Services, Congress prohibited HCFA from reducing dietary service requirements from requirements contained in current rules. HCFA nevertheless deleted a number of current SNF and ICF requirements: the requirement that dietary staff be on duty twelve hours per day, 42 C.F.R. §405.1125(a); the requirement that therapeutic diets be prescribed by the attending physician, 42 C.F.R. §483.35(e) and that therapeutic diets be planned in writing, prepared and served as ordered, with supervision or consultation from the dietitian and advice from the physician whenever necessary, 42 C.F.R. §405.1125(c); the requirement that no more than 14 hours elapse between dinner and breakfast, 42 C.F.R.

§§405.1125(d), 442.331(a); and the requirement that facilities keep a record of each menu as served for 30 days, 42 C.F.R. §442.332(c).

59. The final Conditions of Participation, now Nursing Home Requirements, contradict the explicit language and requirements of current Medicaid law in a number of respects, including, but not limited to, the following:

a. Section 483.12(d) of the regulations, a Level B requirement entitled Admissions Policy, states that effective October 1, 1990, a facility must

> (ii) Not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation or other consideration as a precondition of admission, expedited admission, or continued stay in the facility.

This prohibition against solicitation has been a felony under federal law since the Medicare-Medicaid Anti-Fraud and Abuse Amendments were enacted in 1977. Public Law 95-142 §4, now codified at 42 U.S.C. §1128B. Despite the fact that the anti-solicitation law has been in effect since 1977, which HCFA acknowledges in the preamble to the regulations, 55 Federal Register 5327, the regulatory language unlawfully implies that solicitation is a permissible practice until October 1, 1990.

60. The final Conditions of Participation, now Nursing Home Requirements, are substantially different from the October, 1987 NPRM in a significant number of respects, including, but not limited to, the following:

a. HCFA replaces the NPRM's nomenclature of Conditions of Participation with an entirely new nomenclature, Level A and Level B requirements. Since Federal and State enforcement of nursing home requirements has depended on each requirement's classification--whether a requirement is a Condition of Participation or Standard--the classification given to a requirement is significant.

b. The final rules delete certain Conditions of Participation from the October, 1987 NPRM, such as Social Services, and create new Level A Requirements that did not exist in the October, 1987 NPRM, including §483.12, Admission, Transfer, and Discharge, and §483.13, Resident Behavior and Facility Practice. These changes have major consequences for enforcement.

61. The final Conditions of Participation, now Nursing Home Requirements, directly quote or paraphrase provisions of OBRA without giving any further explanation. Many of the quoted or paraphrased provisions are not "self-executing," but require regulatory explanation and clarification which Congress required but which HCFA fails to provide. Quoted or paraphrased provisions of OBRA include, but are not limited to, the following:

a. Mental health: OBRA for the first time requires nursing homes to identify residents' mental health needs and to provide mental health services. The regulations use the term mental health but give no guidance on such issues as what specific mental health services facilities are required to provide, which staff members are required to provide mental health services, and how mental health services are different from Active Treatment. OBRA's requirement of mental health services is not self-executing.

b. Nurse aide training: OBRA requires nurse aides to be trained but permits aides to work in facilities during the four-month training period if they are "competent" to do the tasks assigned. Training and competency are two separate statutory requirements. The regulations paraphrase the language of the law but fail to explain how it will be determined that aides who are in training are competent to do specific tasks. OBRA's requirement for competency is not self-executing.

62. The final Conditions of Participation, now Nursing Home Requirements, state in numerous instances that the Department will publish "Interpretive Guidelines" to explain additional binding and enforceable requirements on facilities. These Interpretive Guidelines will not be published in the Federal Register for public comment, but will be published through informal publications as issuances. Areas for interpretive guidelines include: resident participation in the assessment process, 54 Federal Register 5321; specification of which resident records must be kept confidential by a facility, id., at 5323; definition of "at any reasonable hour" for purposes of describing when

residents may receive visitors, id., at 5324; rules to ensure that "food is served at the proper temperature and under sanitary conditions," id., at 5329; and description of the kinds of therapeutic activities facilities must provide, id., at 5330-331. Some of these issues that HCFA intends to define through Interpretive Guidelines are statutory requirements under OBRA. For example, the requirement of resident participation in the assessment process is mandated by OBRA, §§1819(c)(1)(A)(i), 1919(c)(1)(A)(i).

VII. Causes of Action

A. Violation of Statute: Regulations Are Inconsistent with the Law

63. Plaintiffs incorporate by reference paragraphs 1-62.

64. The final Conditions of Participation, now Nursing Home Requirements, published by HCFA on February 2, 1989, are inconsistent with and violate the language of the laws they purport to implement, the Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987, the Medicare Catastrophic Coverage Act of 1988, and the Medical Assistance Act.

65. Regulations that are inconsistent with and violate the laws they implement are void and of no force and effect.

B. Violation of Statute: Regulations Were Submitted to the Office of Management and Budget for Review and Comment Prior to Publication in the Federal Register

66. Plaintiffs incorporate by reference paragraphs 1-62.

67. HCFA's submissions of the final Conditions of Participation, now Nursing Home Requirements, to the Office of Management and Budget under the Paperwork Reduction Act for approval before publication as final rules in the Federal Register violates the Omnibus Budget Reconciliation Act's explicit waiver of the Paperwork Reduction Act for the nursing home reform provisions, Sections 4204(b) and 4214(d) of OBRA, and makes the final regulations void and of no force and effect.

C. Violation of the Administrative Procedure Act: Publication of Final Regulations without a Prior Period for Public Notice and Comment

68. Plaintiffs incorporate by reference paragraphs 1-62.

69. HCFA's publication of Conditions of Participation, now Nursing Home Requirements, in final form without first publishing them in proposed form and without first allowing members of the public an opportunity to comment on proposed regulations violates the notice and comment requirements of the Administrative Procedure Act, 5 U.S.C. §553, and makes the final regulations void and of no force and effect.

D. Violation of the Administration Procedure Act: Publication of Final Rules that Are Fundamentally Different from Proposed Rules

70. Plaintiffs incorporate by reference paragraphs 1-62.

71. HCFA's publication of final Conditions of Participation, now Nursing Home Requirements, that are fundamentally and significantly different from the proposed regulations violates the notice and comment requirements of the Administrative Procedure Act, 5 U.S.C. §553, and makes the final regulations void and of no force and effect.

E. Violation of the Administrative Procedure Act: Publication of Final Rules that Quote or Restate the Non Self-Executing Language of the Laws They Purport to Implement without Elaboration

72. Plaintiffs incorporate by reference paragraphs 1-62.

73. HCFA's publication of final Conditions of Participation, now Nursing Home Requirements, that quote or restate the language of the law without any elaboration, when that law is not self-executing, violates the Administrative Procedure Act, 5 U.S.C. §553, and makes the final regulations void and of no force and effect.

F. Violation of Administrative Procedure Act: Intention to Publish Binding Rules through Interpretive Guidelines

74. Plaintiffs incorporate by reference paragraphs 1-62.

75. Plaintiffs stated intention to implement OBRA through informal Interpretive Guidelines that will create additional binding and enforceable requirements on nursing facilities violates the notice and comment requirements of the Administrative Procedure Act, 5 U.S.C. §553.

G. Violation of Administrative Procedure Act: Publication of Final Rules that Are Arbitrary and Capricious

76. Plaintiffs incorporate by reference paragraphs 1-62.

77. HCFA's publication of final Conditions of Participation, now Nursing Home Requirements, which, inter alia, are inconsistent with the law, fail to implement the law, and were published in violation of the Administrative Procedure Act, 5 U.S.C. §553, is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

VIII. Prayer for relief

Wherefore plaintiffs pray that this Court

1. declare that HCFA's publication of final Conditions of Participation, now Nursing Home Requirements, that are inconsistent with and violate the language of the Nursing Home Reform amendments enacted by Congress as part of the Omnibus Budget Reconciliation Act of 1987, the Medicare Catastrophic Coverage Act, and the Medical Assistance Act are void and of no force and effect;

2. declare that HCFA's submission of the final Conditions of Participation, now Nursing Home Requirements, to the Office of Management and Budget for approval under the Paperwork Reduction Act violates the Omnibus Budget Reconcilation Act of 1987;

3. declare that HCFA's publication of final Conditions of Participation, now Nursing Home Requirements, without first publishing them in proposed form and without first allowing members of the public an opportunity to comment violates the notice and comment requirements of the Administrative Procedures Act and makes the final regulations void and of no force and effect;

4. declare that HCFA's publication of final Conditions of Participation, now Nursing Home Requirements, that are fundamentally different from the proposed Conditions of Participation published on October 16, 1987 violates the notice and comment requirements of the Administrative Procedure Act and makes the final regulations void and of no force and effect;

5. declare that HCFA's publication of final Conditions of Participation, now Nursing Home Requirements, that quote or restate the language of the nursing home reform provisions of OBRA, but provide no further elaboration, even though the provisions are not self-executing, violates the

Administrative Procedure Act and makes the final regulations void and of no force and effect;

6. enjoin the Department of Health and Human Services to publish a notice in the Federal Register immediately withdrawing the final regulations published February 2, 1989;

7. enjoin the Department of Health and Human Services from failing to publish promptly in the Federal Register for public comment proposed Conditions of Participation, now Nursing Home Requirements, to allow members of the public at least 120 days to comment, to consider fully the public comments that it receives, and to publish in the Federal Register at least 120 days before their effective date of October 1, 1990 final Conditions of Participation (or Nursing Home Requirements) that fully and adequately implement the nursing home reform requirements of the Omnibus Budget Reconciliation Act of 1987 and the Medicare Catastrophic Coverage Act;

8. grant plaintiffs' costs and reasonable attorneys' fees, as authorized by the Equal Access to Justice Act, 5 U.S.C. §504, and

9. grant such other and further relief as the Court deems necessary and proper.

Respectfully submitted,

Toby S. Edelman

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March 8, 1989

Item 6

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May 19, 1989

Senator William S. Cohen
c/o Adam Understein
322 Hart Senate Office Building
Washington, DC 20510

Dear Senator Cohen:

The Association has involved itself extensively in the issues of nursing home reform as are now being articulated in the regulations developed to implement OBRA 89. We are, therefore, very pleased to have this opportunity to offer our comments for the congressional hearing held on May 18, 1989.

1. Competency Testing: The legal premise upon which the provision of nursing by nonnurses (aides) rests is delegation. Nurses delegate nursing duties to nonnurses after assuring themselves that the nonnurse is competent to provide the nursing duty delegated. The nurse's license is at risk. OBRA's insistence then that the testing of the nurses aides' competency to perform the duties assigned can not be determined by nurses employed by the facility is in direct contradiction to that legal premise.

   It seems to us that our federal law and regulation ought to build on the premise of responsible delegation of duties with appropriate competency testing by the person legally responsible. Where is the chain of accountability when we require competency testing by someone outside the institution? We also find ourselves in the foolish position of allowing competency testing by machines located in institutions but not people.

2. CNA Training: In Maine, we have had training requirements for nurses aides beyond that to be required by OBRA. We have required, since 1975, 100 hours of classroom and clinical training. OBRA requires 75 hours. Our 100 hour courses have included testing of the student's competency. Despite that, we are now being told that we need to retest at least 1/2 of those who have been trained and have been performing as competent nurses aides. This determination is made on the basis of the aforementioned outside competency testing and we think it is wrong and ought to be challenged and changed.

3. CNA Retraining: All nursing assistants who take a break in employment for 24 months or more will be required to go through the entire training program again. We think this is inappropriate and insulting. No other work area requires complete retraining once the training has been accomplished. We believe CNAs, rather than repeat a basic training program, will simply chose not to return to long-term care. We suggest instead a refresher course be required consisting of 16 to 24 hours.

4. CNA Continuing Education: In Maine, nursing home administrators are required to have 24 hours of continuing education per year. There are somewhere around 300 licensed administrators. The Association sponsors some 200 or so hours of CEUs per year and devotes a considerable amount of its resources to continuing education. We are the major purveyor of CEUs for administrators.

   HCFA demands in implementing OBRA that CNAs receive 24 hours of CEUs per year. Maine has approximately 5,000 nurses aides throughout the State who work all three shifts. That translates into 120,000 total hours of CEUs to satisfy the total requirement. While we will not, of course, have to provide 120,000 individual hours because of group participation, the relative number of hours will still be very great, especially when you consider that programs will need to be offered on all three shifts. We would feel that one hour per month or 12 per year would be reasonable. As a comparison, in Maine, RNs are not required to have CEUs nor are physicians (MDs) or hospital administrators.

5. Self Administration of Medication: While we agree that the concept of competent nursing home patients being responsible for taking their own medication seems reasonable, in practical application, it is not. Maine's nursing homes have a mix of mostly very ill, debilitated patients. The days of even debating whether or not patients are appropriately placed in nursing homes is over. While we still sometimes refer to them as residents, they are in fact chronically ill, heavily disabled patients. HCFA has determined, however, through regulation that they are all presumed to be competent to self administer medication unless we prove otherwise. We think that policy is wrong and should be blocked.

6. Physician Compliance: Nursing homes have for some time been held accountable for physician compliance. OBRA continues that policy. We think it is wrong. Nursing homes can only make honest efforts to assure physician responsibility to their patients. To hold the nursing home in noncompliance for physician's noncompliance, with all of the attendant sanctions is placing the facility at risk when it has no absolute authority over the doctor. We do not suggest sanctioning physician behavior only that nursing homes not be held accountable for private physician behavior.

7. Physician Drug and Laboratory Orders: HCFA, in an attempt to write regulations to implement a well intentioned policy of minimizing drug use has promulgated very strict interpretative guidelines. These "guidelines" prescribe testing intervals, drug use combinations, and uses of specific drugs. They are gross interferences in the practice of medicine and nursing, and need to be eliminated.

8. Use of Restraints: Forty-three percent (43%) of Maine's nursing home patients, as reported in the recent HCFA consumer guide, are restrained. That is a very high number and one that we are concerned about. We believe, however, that to now require, as HCFA is doing through its rule-making activity, that restraints only be used in an emergency is irresponsible policy from the patient's point of view.

   Restraints are used in nursing homes primarily to keep patients from injuring themselves. They consist of bed side rails, Geri chairs, and a variety of soft restraints that restrict mobility and are used when patients are judged by nurses to be in danger of injury.

   Each instance of restraint use needs to be evaluated carefully and the patient's right to mobility needs to be evaluated against the potential for self harm. It is documented as mobility increase falls and resulting fractures and other trauma increases. While the nursing home cannot be an absolute guarantor of patient's safety, the dynamics of restraint versus self-injury are best settled through nursing judgement and education. They are not amenable to solution through simplistic regulations.

9. Assurance of Nondeterioration of Patient's Condition: HCFA is attempting to regulate that nursing homes not allow their patients' condition to deteriorate unless they can document it was beyond their control. Most nursing home patients are multiply disabled, extremely old, chronically ill, and in the terminal stage of their lives.

   To even suggest that the nursing home be required to document that it is not responsible for a deterioration in the patient's condition sets up a contest that only God himself could decide. The fact that nursing home care givers are mere mortals is apparently lost on the promulgaters of the regulation who may consider themselves our supreme beings.

   Nursing homes are in fact an appropriate place for many sick elders and nonelders alike to live out their final days. To that extent, we need to promulgate the concept that nursing homes are all hospices whose mission is to help and support the patient and respect his wishes as to how he wants to die as we would respect his wishes as to how he wants to live. The idea that we can guarantee his nondeterioration is in direct conflict with that concept.

10. Assessment: The federal law mandates a comprehensive assessment within four days of admission. This is totally unreasonable and in fact impossible to accomplish. We recommend it be changed to 30 days.

In addition, HCFA's regulations are defining comprehensive as completing a 22 page form for each resident. That form contains the HCFA "minimum" data set. The greatest law ever written only contained 10 lines, yet it takes HCFA 22 pages as its "minimum." Not only that, they ask this same form be recompleted every time there is a major change in the patient's condition and again annually. Good patient care is dependent upon staff being available to render that care not completing 22 page forms. This process needs major congressional oversight.

We thank you for this opportunity to comment on these very important issues for Maine's nursing home patients and care givers. Both Marie Fisher, RNC, Health Services Consultant for the Association, and I would be happy to respond to any questions these comments raised. The comments are based primarily upon Ms. Fisher's extensive knowledge of OBRA and its implications on Maine's nursing homes and her discussions with nursing home administrators and nurses throughout the State of Maine.

Sincerely,

Ronald G. Thurston
Executive Vice President

RGT/dc